Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 10121, Issued: 05-08-20)
(Rev. 10222, Issued: 07-15-20)
(Rev. 10312, Issued: 08-21-20)
(Rev. 10321, Issued: 08-28-20)
(Rev. 10371, Issued: 09-24-20)

Transmittals for Chapter 3

10 - General Inpatient Requirements

- 10.1 - Claim Formats
- 10.2 - Focused Medical Review (FMR)
- 10.3 - Spell of Illness
- 10.4 - Payment of Nonphysician Services for Inpatients
- 10.5 - Hospital Inpatient Bundling

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

- 20.1 - Hospital Operating Payments Under PPS
  - 20.1.1 - Hospital Wage Index
  - 20.1.2 - Outliers
    - 20.1.2.1 - Cost to Charge Ratios
    - 20.1.2.2 - Statewide Average Cost to Charge Ratios
    - 20.1.2.3 - Threshold and Marginal Cost
    - 20.1.2.4 - Transfers
    - 20.1.2.5 - Reconciliation
    - 20.1.2.6 - Time Value of Money
    - 20.1.2.7 - Procedure for Medicare contractors to Perform and Record Outlier Reconciliation Adjustments
    - 20.1.2.8 - Specific Outlier Payments for Burn Cases
    - 20.1.2.9 - Medical Review and Adjustments
    - 20.1.2.10 - Return Codes for Pricer
- 20.2 - Computer Programs Used to Support Prospective Payment System
  - 20.2.1 - Medicare Code Editor (MCE)
    - 20.2.1.1 - Paying Claims Outside of the MCE

20.2.1.1.1 - Requesting to Pay Claims Without MCE Approval

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE

20.2.2 - DRG GROUPER Program

20.2.3 - PPS Pricer Program

20.2.3.1 - Provider-Specific File

20.3 - Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

20.3.1 - Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation

20.3.1.1 - Clarification for Cost Reporting Periods Beginning On or After January 1, 2000

20.3.1.2 - Hold Harmless for Cost Reporting Periods Beginning Before January 1, 2000

20.3.1.3 - Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009

20.3.1.4 - Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2012

20.3.2 - Updates to the Federal Fiscal Year (FY) 2001

20.3.2.1 - Inpatient Hospital Payments and Disproportionate Share Hospital (DSH) Thresholds and Adjustments

20.3.3 - Prospective Payment Changes for Fiscal Year (FY) 2003

20.3.4 - Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond

20.4 - Hospital Capital Payments Under PPS

20.4.1 - Federal Rate

20.4.2 - Hold Harmless Payments

20.4.3 - Blended Payments

20.4.4 - Capital Payments in Puerto Rico

20.4.5 - Old and New Capital

20.4.6 - New Hospitals

20.4.7 - Capital PPS Exception Payments

20.4.8 - Capital Outliers

20.4.9 - Admission Prior to and Discharge After Capital PPS Implementation Date

20.4.10 - Market Basket Update

20.5 - Rural Referral Centers (RRCs)

20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

20.7 - Billing Applicable to PPS

20.7.1- Stays Prior to and Discharge After IPPS Implementation Date

20.7.2 - Split Bills

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

20.7.4 - Cost Outlier Bills With Benefits Exhausted

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare Advantage (MA) Enrollees

30 - Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

30.1.1 - Payment for Inpatient Services Furnished by a CAH

30.1.1.1 - Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or tribal CAH

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH

30.1.3 - Costs of Emergency Room On-Call Providers

30.1.4 - Costs of Ambulance Services

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

40.1 - "Day Count" Rules for All Providers

40.2 - Determining Covered/Noncovered Days and Charges

40.2.1 - Noncovered Admission Followed by Covered Level of Care

40.2.2 - Charges to Beneficiaries for Part A Services

40.2.3 - Determining Covered and Noncovered Charges - Pricer and PS&R

40.2.4 - IPPS Transfers Between Hospitals

40.2.5 - Repeat Admissions

40.2.6 - Leave of Absence

40.3 - Outpatient Services Treated as Inpatient Services

40.3.1 - Billing Procedures to Avoid Duplicate Payments

50 - Adjustment Bills

50.1 - Tolerance Guidelines for Submitting Adjustment Requests

50.2 - Claim Change Reasons

50.3 - Late Charges

60 - Swing-Bed Services

70 - All-Inclusive Rate Providers

70.1 - Providers Using All-Inclusive Rates for Inpatient Part A Charges

80 - Hospitals That Do Not Charge

80.1 - Medicare Summary Notice (MSN) for Services in Hospitals That Do Not Charge

90 - Billing Transplant Services

90.1 - Kidney Transplant - General

90.1.1 - The Standard Kidney Acquisition Charge

90.1.2 - Billing for Kidney Transplant and Acquisition Services

90.1.3 - Billing for Donor Post-Kidney Transplant Complication Services

90.2 - Heart Transplants

90.3 - Stem Cell Transplantation

90.3.1 - Allogeneic for Stem Cell Transplantation

90.3.2 - Autologous Stem Cell Transplantation (AuSCT)

90.4 - Liver Transplants

90.4.1 - Standard Liver Acquisition Charge

90.4.2 - Billing for Liver Transplant and Acquisition Services

90.5 - Pancreas Transplants With Kidney Transplants

90.5.1 - Pancreas Transplants Alone (PA)

90.6 - Intestinal and Multi-Visceral Transplants

100 - Billing Instructions for Specific Situations

100.1 - Billing for Abortion Services

100.2 - Payment for CRNA or AA Services

100.3 - Resident and Interns Not Under Approved Teaching Programs

100.4 - Billing for Services After Termination of Provider Agreement

100.4.1 - Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number

100.5 - Review of Hospital Admissions of Patients Who Have Elected Hospice Care

100.6 - Inpatient Renal Services

100.7 - Lung Volume Reduction Surgery

100.8 - Replaced Devices Offered Without Cost or With a Credit

100.9 – Requirements for Processing Non Veterans Administration (VA) Authorized Inpatient Claims

130 - Coordination With the Quality Improvement Organization (QIO)

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

140.1 - Medicare IRF Classification Requirements

140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Facilities

140.1.2 - Additional Criteria That Must Be Met By Inpatient Rehabilitation Units

140.1.3 - Verification Process Used to Determine if the Inpatient Rehabilitation Facility Met the Classification Criteria

140.1.4 - New IRFs

140.1.5 - Changes in the Status of an IRF Unit

140.1.6 - New IRF Beds

140.1.7 - Change of Ownership or Leasing

140.1.8 - Mergers

140.1.9 - Retroactive Adjustments For Provisionally Excluded IRFs or IRF Beds

140.2 - Payment Provisions Under IRF PPS

140.2.1 - Phase-In Implementation

140.2.2 - Payment Adjustment Factors and Rates

140.2.3 - Case-Mix Groups

140.2.4 - Case-Level Adjustments

140.2.5 - Facility-Level Adjustments

140.2.5.1 - Area Wage Adjustments

140.2.5.2 - Rural Adjustment

140.2.5.3 - Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

140.2.5.4 - Teaching Status Adjustment

140.2.5.4.1 - FTE Resident Cap

140.2.5.5 - Outliers

140.2.6 - Cost-to-Charge Ratios

140.2.7- Use of a National Average Cost-to-Charge Ratio

140.2.8- Reconciling Outlier Payments for IRF

140.2.9-Time Value of Money

140.2.10 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs

140.2.11- Quality Reporting Program

140.3 - Billing Requirements Under IRF PPS

140.3.1 - Shared Systems and CWF Edits

140.3.2 - IRF PPS Pricer Software

140.3.3 - Remittance Advices

150 - Long Term Care Hospitals (LTCHs) PPS

150.1 - Background

150.2 - Statutory Requirements

150.3 - Affected Medicare Providers

150.4 - Revision of the Qualification Criterion for LTCHs

150.5 - Payment Provisions Under LTCH PPS

150.5.1 - Budget Neutrality

150.5.2 - Budget Neutrality Offset

150.6 - Beneficiary Liability

150.7 - Patient Classification System

150.8 - Relative Weights

150.9 - Payment Rate

150.9.1 - Case-Level Adjustments

150.9.1.1 - Short-Stay Outliers

150.9.1.2 - Interrupted Stays

150.9.1.3 - Payments for Special Cases

150.9.1.4 - Payment Policy for Co-Located Providers

150.9.1.5 - High Cost Outlier Cases

150.10 - Facility-Level Adjustments

150.10.1 - Phase-in Implementation

150.11 - Requirements for Provider Education and Training

150.12 - Claims Processing and Billing

150.12.1 - Processing Bills Between October 1, 2002, and the Implementation Date

150.13 - Billing Requirements Under LTCH PPS

150.14 - Stays Prior to and Discharge After PPS Implementation Date

150.14.1-Crossover Patients in New LTCHs

150.15 - System Edits

150.16 - Billing Ancillary Services Under LTCH PPS

150.17 - Benefits Exhausted

150.17.1 - Assumptions for Use in Examples Below

150.17.1.1 - Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)

150.17.1.2 - Example 2: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

150.17.1.3 - Example 3: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (20 day stay)

150.17.1.4 - Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)

150.17.1.5 - Example 5: Only LTR Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

150.18 - Provider Interim Payment (PIP)

150.19 - Interim Billing

150.20 - Intermediary Benefit Payment Report (IBPR)

150.21 - Remittance Advices (RAs)

150.22 - Medicare Summary Notices (MSNs)

150.23 - LTCH Pricer Software

150.23.1 - Inputs/Outputs to Pricer

150.24 - Determining the Cost-to-Charge Ratio

150.25 - Statewide Average Cost-to-Charge Ratios

150.26 - Reconciliation

150.27 - Time Value of Money

150.28 Procedure for Medicare contractors to Perform and Record Outlier Reconciliation Adjustments

160 - Necessary Changes to Implement Special Add-On Payments for New Technologies

160.1 - Special Add-On Payments For New Technologies

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

160.1.2 - Remittance Advice Impact

170 - Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI) Claims

170.1 - RNHCI Election Process

170.1.1 - Requirement for RNHCI Election

170.1.2 - Revocation of RNHCI Election

170.1.3 - Completion of the Notice of Election for RNHCI

170.1.4 - Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections

170.2 - Billing Process for RNHCI Services

170.2.1 - When to Bill for RNHCI Services

170.2.2 - Required Data Elements on Claims for RNHCI Services

170.3 - RNHCI Claims Processing By the Medicare Contractor with RNHCI Specialty Workload

170.3.1 - RNHCI Claims Not Billed to Original Medicare

170.4 - Informing Beneficiaries of the Results of RNHCI Claims Processing

180 - Processing Claims For Beneficiaries with RNHCI Elections by Contractors without RNHCI Specialty Workloads

180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

180.2 - Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

190 - Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

190.1 - Background

190.2 - Statutory Requirements

190.3 - Affected Medicare Providers

190.4 - Federal Per Diem Base Rate

190.4.1 - Standardization Factor

190.4.2 - Budget Neutrality

190.4.2.1 - Budget Neutrality Components

190.4.3 - Annual Update

190.4.4 - Calculating the Federal Payment Rate

190.5 - Patient-Level Adjustments

190.5.1 - Diagnosis-Related Groups (DRGs) Adjustments

190.5.2 - Application of Code First

190.5.3 - Comorbidity Adjustments

190.5.4 - Age Adjustments

190.5.5 - Variable Per Diem Adjustments

190.6 - Facility-Level Adjustments

190.6.1 - Wage Index

190.6.2 - Rural Location Adjustment

190.6.3 - Teaching Status Adjustment

190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap

190.6.3.2 - Reconciliation of Teaching Adjustment on Cost Report

190.6.4 - Emergency Department (ED) Adjustment

190.6.4.1 - Source of Admission for IPF PPS Claims for Payment of ED Adjustment

190.6.5 - Cost-of- Living Adjustment (COLA) for Alaska and Hawaii

190.7 - Other Payment Policies

190.7.1 - Interrupted Stays

190.7.2 - Outlier Policy

190.7.2.1 - How to Calculate Outlier Payments

190.7.2.2 - Determining the Cost-to-Charge Ratio

190.7.2.3 Outlier Reconciliation

190.7.2.4. Time Value of Money

190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

190.7.3 - Electroconvulsive Therapy (ECT) Payment

190.7.4 - Stop Loss Provision (Transition Period Only)

190.8 - Transition (Phase-In Implementation)

190.8.1 - Implementation Date for Provider

190.9 - Definition of New IPF Providers Versus TEFRA Providers

190.9.1 - New Providers Defined

190.10 - Claims Processing Requirements Under IPF PPS

190.10.1 - General Rules

190.10.2 - Billing Period

190.10.3 - Patient Status Coding

190.10.4 - Reporting ECT Treatments

190.10.5 - Outpatient Services Treated as Inpatient Services

190.10.6 - Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period

190.10.7 - Billing for Interrupted Stays

190.10.8 - Grace Days

190.10.9 - Billing Stays Prior to and Discharge After PPS Implementation Date

190.10.10 - Billing Ancillary Services Under IPF PPS

190.10.11 - Covered Costs Not Included in IPF PPS Amount

190.10.12 - Same Day Transfer Claims

190.10.13 - Remittance Advice - Reserved

190.10.14 - Medicare Summary Notices and Explanation of Medicare Benefits

190.11 - Benefit Application and Limits-190 Days

190.12 - Beneficiary Liability

190.12.1 - Benefits Exhaust

190.13 - Periodic Interim Payments (PIP)

190.14 - Intermediary Benefit Payment Report (IBPR)

190.15 - Monitoring Implementation of IPF PPS Through Pulse

190.16 - IPF PPS System Edits

190.17 - IPF PPS PRICER Software

190.17.1 - Inputs/Outputs to PRICER

200 - Electronic Health Record (EHR) Incentive Payments

200.1 - Payment Calculation

200.2 - Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

250.18 - Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

Addendum A - Provider Specific File

10 - General Inpatient Requirements

(Rev. 1, 10-01-03)
HO-400, HO-400.G, HO-403, HO-412

The hospital may bill only for services provided. If the provider billing system initiates billing based on services ordered, the provider must confirm that the service has been provided before billing either the A/B MAC (B) or A/B MAC (A).

The provider agreement to participate in the program requires the provider to submit all information necessary to support claims for services. Failure to submit such information in an individual case will result in denial of the entire claim, the charging of utilization in inpatient cases to the beneficiary record, and a prohibition against the provider billing or collecting from the beneficiary or other person for any services on the claim. A provider with a common practice of failing to submit necessary information in connection with its claims subjects itself to possible termination of its participation in the program. (See chapter 1.)

State agencies will find that a significant deficiency exists in complying with the conditions of participation if the hospital repeatedly fails to transfer appropriate medical information when patients are transferred to other health facilities. Appropriate medical information includes the discharge summary, the physician's medical orders, and a summary of departmental medical records. The hospital must obtain the patient's consent for the release of medical information as soon as the decision to transfer is made, unless a blanket authorization was obtained at admission.

10.1 - Claim Formats

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

A. - Institutional Claim Formats

The ASC X12 837 institutional claim format, or where permissible, Form CMS-1450, Inpatient and/or Outpatient Billing, is used for all provider billing, except for the professional component of physicians services. (Refer to paragraph B for the appropriate professional claim formats.) The ASC X12 837 institutional claim format and Form CMS-1450 are processed by the provider's A/B MAC (A). See Chapter 25 for instructions for hospital services.)

Providers submitting claims on paper are responsible for purchasing their own paper forms.

B. - Professional Claim Formats

The ASC X12 837 professional claim format, or where permissible, Form CMS-1500 is the prescribed format for claims prepared by physicians and nonphysician practitioners whether or not the claims are assigned. Institutional providers may use the ASC X12 837 professional claim format or the Form CMS-1500 to bill the A/B MAC (B) for the professional component of physicians' services where applicable. (For more information about the CMS-1500 claim form, refer to Chapter 26. Information about billing for physician and other supplier services can be found in this chapter as well as chapters throughout this manual relative to specific policies and topics.)

Providers submitting claims on paper are responsible for purchasing their own paper forms.

C. - Form CMS-1490S Patient's Request for Medicare Payment

Only beneficiaries (or their representatives) who complete and file their own claims use this form. Providers have no need for this form.

10.2 - Focused Medical Review (FMR)

(Rev. 1, 10-01-03)
HO-419, HH-450, HH-452, HH-462.1

This section has been moved to the Program Integrity Manual, which can be found at the following Internet address http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

10.3 - Spell of Illness

(Rev. 1, 10-01-03)
A3-3622

The A/B MAC (A) or (HHH) makes spell of illness determinations in accordance with the Medicare Benefit Policy Manual, Chapter 3, and these special instructions.

A. - Beginning a Spell of Illness in Nonparticipating Provider

The noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or an SNF that meets all requirements in the definition of such an institution even though it may not be participating.

It is most unlikely that a nonparticipating hospital that is not accredited by JCAHO or a nonparticipating SNF satisfies the conditions of participation, particularly with regard to utilization review. Therefore, for spell of illness purposes, the A/B MAC (A) or (HHH) assumes that nonparticipating providers are not qualified providers in the absence of evidence to the contrary. Situations that might constitute such contrary evidence include cases where the provider recently dropped out of the program or, after a survey by the State agency, decided not to participate even though the conditions of participation were met. Hospitals accredited by JCAHO are deemed to meet all requirements except utilization review. For such a hospital, the A/B MAC (A) determines through the RO whether the hospital has a utilization review plan in effect.

B. - Continuing a Spell of Illness

1. Hospital Services

For purposes of continuing a spell of illness in a hospital, the hospital in which the stay occurs need not meet all requirements that are necessary for starting a spell of illness. If there has been a stay in a hospital that might continue the spell of illness and the A/B MAC (A) cannot ascertain its status, the A/B MAC (A) contacts the RO, which maintains a list of all medical facilities and their status.

2. SNF Services

For purposes of continuing a spell of illness in a SNF the spell of illness ends when the beneficiary no longer needs or receives a Medicare covered level of care.

The A/B MAC (A) uses the following seven presumptions to determine whether the skilled level of care standards were met during a prior SNF stay. If the information upon which to base a presumption is not readily available, the A/B MAC (A) may, at its discretion, review the beneficiary's medical records to determine whether the beneficiary was an inpatient of an SNF for purposes of ending a spell of illness.

These special rules for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is seeking to continue a benefit period, but also where it results in the beneficiary starting a new benefit period. If the applicable skilled level of care standards were met during a prior SNF stay, the spell of illness is continued with current utilization available to the beneficiary. If the applicable skilled level of care standards were not met during a prior SNF stay, the spell of illness is not continued. A new spell of illness restores full utilization and imposes a cash deductible.

Presumptions:

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation of liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a noncertified bed. See Chapter 30.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules in Chapter 30. (This presumption does not apply to placement in a noncertified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in an SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Rebuttal of Presumptions

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation. Although Presumptions 1 through 4 are not in themselves rebuttable, a beneficiary may seek to reverse a benefit period determination that was dictated by one of these presumptions by timely appealing the prior Medicare or Medicaid claim determination which triggered the presumption.

Presumptions 5 through 7 can be rebutted by beneficiary showings that the level of care needed or received is other than that which the presumption dictates. Rebuttal showings are permitted at both A/B MAC (A) determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial. Decisions under presumptions 5 through 7 require the A/B MAC (A) to send a notice to advise the beneficiary of the basis for the determination and the right to present evidence to rebut the determination on reconsideration.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. For example, prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for an SNF stay because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when Medicare SNF payment is denied, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations to extend a benefit period if this would be to the beneficiary's advantage.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption.

Medicare no payment bills submitted by an SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no payment bills which lead to Medicaid program payment determinations. If an SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, request compliance. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Some of the presumptions require knowledge of Medicaid's claims processing involvement with the prior claim. The A/B MAC (A) uses current bill data, accompanying documentation, bill history files, and telephone contacts with the prior stay facility and/or the Medicaid agency to develop the Medicaid aspects. It does not continue Medicaid development beyond a telephone contact. It concludes its consideration of the presumption at this point based upon the Medicaid information available.

10.4 - Payment of Nonphysician Services for Inpatients

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS.

A. - Other Medical Items, Supplies, and Services

The following medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services);
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;
- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic;
- Total parenteral nutrition (TPN) services; and
- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient.

The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540.

EXCEPTIONS:

- **Pneumococcal Vaccine -** is payable under Part B only and is billed by the hospital using the ASC X12 837 institutional claim format or on the Form CMS-1450.

- **Ambulance Service** - For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted it does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately using the ASC X12 837 institutional claim format or on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the A/B MAC (B) by the ambulance operator or beneficiary, as appropriate, if an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance trip is considered part of the DRG, and not separately billable, if the resident hospital is under PPS.

- **Part B Inpatient Services** - Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services. See Chapter 4 for a description of Part B inpatient services.

- **Anesthetist Services "Incident to" Physician Services** - If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of the hospital's most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist's service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ certified registered nurse anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital's cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

B. - Exceptions/Waivers

These provisions were waived before cost reporting periods beginning on or after October 1, 1986, under certain circumstances. The basic criteria for waiver was that services furnished by outside suppliers are so extensive that a sudden change in billing practices would threaten the stability of patient care. Specific criteria for waiver and processing procedures are in §2804 of the Provider Reimbursement Manual (CMS Pub. 15-1).

10.5 - Hospital Inpatient Bundling

(Rev. 668, Issued: 09-02-05; Effective: Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments; Implementation: 01-03-06)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay. The Common Working File (CWF) performs reject edits to incoming claims from independent suppliers of ambulance services. The CWF searches paid claim history and compares the line item service date on an ambulance claim to the admission and discharge dates on a hospital inpatient stay. The CWF rejects the line item when the ambulance line item service date falls within the admission and discharge dates on a hospital inpatient claim. Based on CWF rejects, the A/B MAC (B) must deny line items for ambulance services billed by independent suppliers that should be bundled to the hospital.

Upon receipt of a hospital inpatient claim, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on an ambulance claim billed by an independent supplier. The CWF shall generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of the unsolicited response, the A/B MAC (B) shall adjust the ambulance claim and recoup the payment.

Ambulance services with a date of service that is the same as the admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules.

The CWF performs an additional edit before determining if the ambulance line item should be rejected when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF) and is transported via ambulance to an acute care hospital to receive specialized services. The CWF edits the claim for the presence of occurrence span code 74 (non-covered level of care) and the associated occurrence span code from and through dates. The CWF bypasses the reject edit when the ambulance line item service date falls within the occurrence span code 74 from and through dates plus one day. In this case, the ambulance line item is separately payable. The CWF rejects the ambulance line item when the service date falls outside the occurrence span code 74 from and through dates plus one day.

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 10210, Issued: 07-10-2020, Effective: 08-10-2020 , Implementation: 08-10-2020)

A. - General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the

50 States. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid at a lower percentage rate (plus adjustments for sequestration when applicable) instead of determining the payment amount of the claim through the Inpatient Prospective Payment System (IPPS) or the Outpatient Prospective Payment System (OPPS).

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

The OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first 2 years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B. - Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18.

Hospitals located outside the 50 States.

- Hospitals participating in a CMS-approved demonstration project or State payment control system.

- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

C. - Situations Requiring Special Handling

1. Sole community hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2. Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as comprehensive cancer centers or clinical research centers;

- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3. Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4. Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5. Kidney, heart, and liver acquisition costs incurred by approved transplant centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6. Religious nonmedical health care institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by Pricer.

7. Transferring hospitals with discharges assigned to MS-DRG 789 (neonates, died or transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8. Nonparticipating hospitals furnishing emergency services are not included in PPS.

9. Veterans Administration (VA) hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10. A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11. The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.

- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12. Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13. Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and

- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D. - MS-DRG Classification

The MS-DRGs (Medicare Severity DRGs) are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 745 diagnosis related groups (DRGs).

The following MS-DRGs receive special attention:

- **MS-DRGs No. 981-983** - Represent discharges with valid data, but the surgical procedure is unrelated to the principal diagnosis. MS-DRGs 981 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ MCC), 982 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ CC), and 983 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/o CC/MCC) each have relative weights assigned to them and will be paid. The hospital must review the record on each of these MS-DRGs in the remittance record and determine that where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The A/B MAC (A) may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment.

- **MS-DRG No. 998** - Represents a discharge reporting a principle diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for MS-DRG assignment purposes. A/B MACs (A) will return the claims. The hospital must enter the corrected principal diagnosis for proper MS-DRG assignment and resubmit the claim.

- **MS-DRG No. 999** - Represents a discharge with invalid data, making it ungroupable. A/B MACs (A) return the claims for correction of data elements affecting proper MS-DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E. - Difference in Age/Admission Versus Discharge
HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

20.1 - Hospital Operating Payments Under PPS

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Under the PPS, Medicare payment for hospital

inpatient operating costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the PPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the PPS are made on the basis of the standardized amounts, some categories of hospitals are paid based on the higher of a hospital-specific rate determined from their costs in a base year as specified in the statute, or the PPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and small rural Medicare-dependent hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although the statutory payment formulas for SCHs and MDHs differ as described below in section 20.6).

The existing regulations governing payments to hospitals under the PPS are located in 42 CFR Part 412, Subparts A through M.

20.1.1 - Hospital Wage Index
(Rev. 70, 01-23-04)

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the

national average hospital wage level." This adjustment factor is the wage index. CMS defines hospital geographic areas (labor market areas) based on the definitions of urban (e.g., Metropolitan Statistical Areas (MSAs)) and rural areas issued by the Office of Management and Budget.

The Act further requires the wage index to be updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. These data are collected on Worksheet S-3, Parts II and III of the Medicare Cost Report (Form CMS-2552). To ensure the accuracy of the wage index, fiscal intermediaries are required to perform annual desk reviews of hospitals' wage data. CMS also publishes the wage data, and allows hospitals an opportunity to review and request corrections to the data, before the wage index is finalized.

In computing the wage index, CMS derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals surveyed in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. If a labor market area's average hourly wage is greater than the national average, the area's wage index value will be greater than 1.0000. If an area's average hourly wage is less than the national average, the area's wage index value will be less than 1.0000. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.

Section 4410 of Public Law 105-33 provides that, for discharges on or after October 1, 1997, the area wage index value applicable to any hospital that is located in an urban area may not be less than the area wage index value applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply.

20.1.2 - Outliers

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

§1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

The actual determination of whether a case qualifies for outlier payments is made by the Medicare contractor using Pricer, which takes into account both operating and capital costs and Medicare severity-diagnostic related group (MS-DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The

estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn MS-DRGs). Any outlier payment due is added to the MS-DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit the CMS Web site at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

The Medicare contractor may choose to review outliers if data analysis deems it a priority.

The IPPS outliers are not applicable to non-PPS hospitals. The Pricer program makes all outlier determinations except for the medical review determination. Outlier payments apply only to the Federal portion of a capital PPS payment.

20.1.2.1 - Cost to Charge Ratios

(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

For discharges before August 8, 2003, Medicare contractors used the latest final settled cost report to determine a hospital's cost-to-charge ratios (CCRs). For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 Medicare contractors are to use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR (to download PM A-03-058, visit our Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/CMS-Program-Memoranda. http://www.cms.hhs.gov/Transmittals/Downloads/A03058.pdf). For all other hospitals, effective October 1, 2003, Medicare contractors are to use CCRs from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs.

A. - Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs is determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Effective November 7, 2005, the following methodology shall be used to calculate a hospital's operating and capital CCRs.

Inpatient PPS Operating CCR

1) Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).

2) Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.

Inpatient Capital CCR

1) Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 10, sum of lines 25 through 30, plus column 12, sum of lines 25 through 30 plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column 6, line 101 plus column 8 line 101.

2) Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.

B. - Use of Alternative Data in Determining CCRs For Hospitals

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The CMS Regional Office, in conjunction with the CMS Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. Medicare contractors shall send notification to the Central Office via email at outliersIPPS@cms.hhs.gov.

C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

The Medicare contractor shall continue to update a hospital's operating and capital CCRs (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Subject to the approval of CMS, a hospital's operating and/or capital CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all hospital claims processed after the update.

D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the Hospital

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a hospital will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the hospital, the Medicare contractor notifies the CMS regional office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital or Medicare contractor for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

E. - Notification to Hospitals Under the IPPS of a Change in the CCR

The Medicare contractor shall notify a hospital whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a hospital about a change to their CCR(s).

F. - Hospital Mergers, Conversions, and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, Medicare contractors shall continue to use the operating and capital CCRs calculated from the Medicare cost report associated with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, Medicare contractors may use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). For non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number the Statewide average CCR may be applied to that hospital. However, as noted in part C above, the Medicare contractor or the hospital may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report before it converted to IPPS status, or received a new provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors should contact the CMS Regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the operating or capital CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

20.1.2.2 - Statewide Average Cost-to-Charge Ratios

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For discharges prior to August 8, 2003, Statewide average CCRs are used in those instances in which a hospital's operating or capital CCRs fall above or below reasonable parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the Medicare contractor may use a Statewide average CCR if it is unable to determine an accurate operating or capital CCR for a hospital in one of the following circumstances:

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 489.18.)

2. Hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b) of the CFR.

3. Other hospitals which accurate data with which to calculate either an operating or capital CCR (or both) are not available.

However, the policies of §20.1.2.1 part C and part E can be applied as an alternative to the Statewide average.

For those hospitals assigned the Statewide average operating and/or capital CCRs, these CCRs must be updated every October 1 based on the latest Statewide average CCRs published in each year's annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of §20.1.2.1 part C of this manual.

A hospital is not assigned the Statewide average CCR if its CCR falls below 3 standard deviations from the national mean CCR. In such a case, the hospital's actual operating or capital CCR is used.

20.1.2.3 - Threshold and Marginal Cost

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The Medicare contractor, using Pricer, determines an appropriate additional payment for inpatient services where hospital charges for covered services furnished to the beneficiary, adjusted for cost, are extraordinarily high. CMS annually determines, and includes in the annual IPPS Final Rule and in Pricer, the threshold beyond which a cost outlier is paid. The additional payment amount is the difference between the estimated cost for the discharge (determined by multiplying the hospital specific CCR by the hospital's charges for the discharge) and the threshold criteria established for the applicable DRG multiplied by a marginal cost factor of 80 percent. (The marginal cost factor for burn cases is 90 percent, as described in §20.1.2.8.) CMS includes the marginal cost factor in Pricer. For more explanation on the calculation of outliers visit our Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage

20.1.2.4 - Transfers

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. Transfers Between IPPS Hospitals

For transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus one day.

The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. For further information on transfers between IPPS hospitals, see §40.2.4 part A of this manual.

B. - Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that do not Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the postacute care transfer policy, the transferring hospital is paid the full IPPS rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold and payment are calculated the same as any other discharge without a transfer.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that do not fall within a DRG that is subject to the postacute care transfer policy, see §40.2.4 part B of this manual.

C. - Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is subject to the postacute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus one day. If a discharge is assigned to a special pay DRG subject to the post acute care transfer policy the outlier threshold is equal to the fixed-loss cost outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by 0.5 plus the product of the 0.5 multiplied by a number equal to the length of stay plus one day multiplied by 0.5.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that fall within a DRG subject to the postacute care transfer policy, see §40.2.4 part C and D.

20.1.2.5 - Reconciliation

(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

A. - General

Under 42 CFR §412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that Medicare contractors identified using the criteria in §I.A. of PM A-03-058 (under which Medicare contractors identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS Central Office, a hospital's outlier claims will be reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2. Total outlier payments in that cost reporting period exceed $500,000.

To determine if a hospital meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The first criterion requires a 10 percentage point fluctuation in the operating CCR only (and not the capital CCR). However, if a hospital meets both criteria, claims will be reconciled using the operating and capital CCRs from the final settled cost report.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov.

Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the Central Office via email at outliersIPPS@cms.hhs.gov. Upon approval of the CMS Regional and Central Office that a hospital's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §20.1.2.7.

B. - Reconciling Outlier Payments for those Hospitals Identified in PM A-03-058

As stated above, for a hospital that met the criteria in §I.A. of PM A-03-058, reconciliation begins for discharges occurring on or after August 8, 2003. To establish whether a hospital's outlier payments are subject to reprocessing, Medicare contractors determine if the CCR and total outlier payments from the entire cost reporting period meet the two criteria in part A of this section. However, if both criteria for reconciliation are met, only the discharges that occurred between August 8, 2003 and the end of the cost reporting period will be reconciled. These hospitals will be subject to reconciliation in subsequent cost reporting periods if they meet the two criteria outlined in part A of this section. See example A below.

The Medicare contractors shall notify the CMS Regional Office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

EXAMPLE A:

Cost Reporting Period: 09/01/2002-08/31/2003

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively or final settled 2002 cost report)
Final settled operating CCR from 09/01/2002-08/31/2003 cost report: 0.50

Total outlier payout in 09/01/2002-08/31/2003 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the provider's claims for discharges from August 8, 2003 through August 31, 2003 shall be reconciled using the correct CCR of 0.50. The same criteria shall be applied to the cost report beginning on 09/01/2003 to determine

whether reconciliation of outlier payments for that cost reporting period is necessary. For details on how to apply multiple CCRs in a cost reporting period, see example C below.

C. - Reconciling Outlier Payments for those Hospitals Not Identified in PM A-03-058

Beginning with the first cost reporting period starting on or after October 1, 2003, all hospitals are subject to the reconciliation policies set forth in this section. If a hospital meets the criteria in part A of this section, the Medicare contractor shall notify the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE B:

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor shall notify the CMS Regional Office and Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. (See Example C below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE C:

Cost Reporting Period: 01/01/2004-12/31/2004
Operating CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR could be from the tentatively settled 2001 cost report)

- 0.50 from 04/01/2004-12/31/2004 (This CCR could be from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total Outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000
Weighted Average CCR: 0.474

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	***366**		**(a)+(b) =0.4742**

***NOTE**: There are 366 days in the year because 2004 was a leap year.

The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.474 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.

20.1.2.6 - Time Value of Money

(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under §20.1.2.5, outlier payment may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula will be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation. **NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification via email from the Medicare contractor.

The following is an example of the computation of the adjustment to account for the time value of money:

EXAMPLE

Cost Reporting Period: 01/01/2004-12/31/2004

Midpoint of Cost Reporting Period: 07/01/2004
Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

Operating CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has total outlier payments greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional and Central Office.

The Medicare contractor reprocesses and reconciles the claims. The reprocessing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money:
(4.625 / 365) * 549 = 6.9565%

Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.

20.1.2.7 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via email to outliersIPPS@cms.hhs.gov and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 - Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 - Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being reconciled aside from the elements for the operating and capital CCRs.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - Type of Bill (TOB) equals 11X
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and

revised operating and capital amounts (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II. **NOTE**: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.

    For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. **NOTE**: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the CMS Central Office via the address and email address provided in §20.1.2.1 (B).

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Revised Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Difference between these amounts
Original Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Revised Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Revised Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Difference between these amounts
Original Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Revised Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Difference between these amounts
Original Outlier Amount (Value Code 17)

List of Data Elements for FISS Extract
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
TOT CHRG – total billed charges (claim page 3)
COV CHRG – total covered charges (claim page 3)
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original UNCOMP CARE AMT (claim page 40)
Revised UNCOMP CARE AMT (claim page 40)
Difference between these amounts

List of Data Elements for FISS Extract
Original VAL PURC ADJ AMT (claim page 40)
Revised VAL PURC ADJ AMT (claim page 40)
Difference between these amounts
Original READMIS ADJ AMT (claim page 40)
Revised READMIS ADJ AMT (claim page 40)
Difference between these amounts
Original HAC PAYMENT AMT (claim page 40)
Revised HAC PAYMENT AMT (claim page 40)
Difference between these amounts
Original EHR PAY ADJ AMT (claim page 40)
Revised EHR PAY ADJ AMT (claim page 40)
Difference between these amounts
Original PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Revised PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

20.1.2.8 - Special Outlier Payments for Burn Cases

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates is computed using the same methodology (as stated above in section 20.1.2.3) except that the payment is made using a marginal cost factor of 90 percent instead of 80 percent.

20.1.2.9 - Medical Review and Adjustments

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Effective April 1, 2008, QIOs are no longer performing the majority of medical review for payment of acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims. These reviews are the responsibility of the A/B MACs (A). An exception occurs when a provider requests a higher-weighted DRG review from the QIO. The QIO will continue to perform those reviews.

The A/B MAC (A) may review a sample of cost outlier cases after payment. The charges for any services identified as non-covered through this review are denied and any outlier payment made for these services is recovered, as appropriate, after a determination as to the provider's liability has been made.

If the A/B MAC (A) finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital may be subject to medical review, and this review may be conducted

prior to payment until the A/B MAC (A) determines that appropriate corrective actions have been taken.

When the A/B MAC (A) reviews cost outlier cases, they shall do so using the medical records and itemized charges, to verify the following:

1. The admission was medically necessary and appropriate;

2. Services were medically necessary and delivered in the most appropriate setting;

3. Services were ordered by the physician, actually furnished, and not duplicatively billed; and

4. The diagnostic and procedural coding are correct.

Where the A/B MAC (A)'s decision changes previously processed bills, an adjustment bill is prepared to correct the bill.

When the hospital provides the A/B MAC (A) with medical records for cost outlier review, the hospital must indicate the precise revenue code for each charge billed. In case adjustments are needed, revenue codes are necessary to ensure proper accounting for cost report purposes. It is not acceptable for the hospital to merely provide listings of revenue codes expecting the A/B MAC (A) to assign the charges to the appropriate code. If the correct revenue codes are not provided, the A/B MAC (A) will deny the bill.

20.1.2.10 - Return Codes for Pricer

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

The following return codes are calculated by PRICER and passed back to the calling program. Depending on the type of payment and case, return codes 30, 44, 33, 40 and 42 indicate that an outlier would be paid if the cost-to-charge ratio would rise by 20 percentage points. If a provider(s) (CCR rises by 10 percentage points and) meets the criteria of reconciliation, the CMS Central Office uses return codes 30, 44, 33, 40 and 42 to determine a smaller pool of claims for reprocessing claims due to outlier reconciliation.

<u>Acute Care</u>

Return Code 00: Paid normal DRG payment.

Return Code 02: Paid normal DRG payment plus a cost outlier.

Return Code 14: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay.

Return Code 16: Paid normal DRG payment plus a cost outlier with per diem days equal to or greater than geometric mean length of stay.

Return Code 30: Paid normal DRG payment and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Return Code 44: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Transfer Cases

Return Code 03: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated.

Return Code 05: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates case qualified for a cost outlier payment.

Return Code 06: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates provider refused cost outlier payment.

Return Code 33: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Postacute Transfer Cases

Return Code 10: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay the standard payment is also calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 12: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 40: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Return Code 42: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

20.2 - Computer Programs Used to Support Prospective Payment System

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Medicare Code Editor

The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include correct diagnosis and procedure coding, coverage, and clinical edits.

Built into the MCE, which is the first portion of the Grouper program, are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review may be conducted by the A/B MACs (A), using medical records and the approved claim.

Grouper Program

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

Pricer Program

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary who's benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below. Hospitals and hospital claims in multiple geographic areas may obtain a Pricer from

National Technical Institute
U.S. Department of Commerce
NTIS
Springfield, VA 22161.

Hospitals may also download a PC Pricer that will process one record at the time from the CMS Web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html.

20.2.1 - Medicare Code Editor (MCE)

(Rev. 3504, Issued: 04-28-16, Effective: 10-01-16, Implementation: 10- 03-16)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the MS-DRG assignment:

- **Code Edits -** Examines a record for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

- **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services where covered.

- **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B. - Implementation Requirements

The A/B MAC (A) processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (condition code C1 or C3). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. - Bill System/MCE Interface

The A/B MAC (A) installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the bill:

- Age;

- Sex;

- Discharge status;

- Diagnosis (25 maximum - principal diagnosis and up to 24 additional diagnoses);

- Procedures (25 maximum); and

- Discharge date.

The MCE provides the A/B MAC (A) an analysis of "errors" on the bill as described in subsection D. The A/B MAC (A) develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. - Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the A/B MAC (A) considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes. **Applicable** ICD-10-CM and ICD-10-PCS codes will be provided as part of the annual updates when ICD-10 is implemented.

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid diagnosis and procedure codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total

procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the bill to the provider.

For a list of valid diagnosis or procedure codes see the "International Classification of Diseases" revision applicable to the date of the inpatient discharge or other service and the "Addendum/Errata" and new codes furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume l (Diseases)" and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

3. Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the bill.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.

- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the MCE, which is posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS and select the final rule for the applicable year from the list on the left. Then select the FYxxxx Final Rule Data Files, and scoll down to the Definition of Medicare Code Edits.

If the A/B MAC (A) edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis or patient's age before returning the bill.

5. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).

- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The MCE contains listings of male and female related diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

6. Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of diagnosis codes identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." The A/B MAC (A) may review claims with specific codes in the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If these codes are identified without a secondary diagnosis, the A/B MAC (A) returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The A/B MAC (A) will return the bill requesting that the non-covered procedure and its associated charges be removed from the covered claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The MS-DRG Grouper logic assign a patient to different MS-DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using diagnosis codes correctly, the A/B MAC (A) requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the A/B MAC (A) changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The A/B MAC (A) assigns the appropriate closed biopsy code after reviewing the medical information.

Effective October 1, 2010, the open biopsy check edit was discontinued and was only used when processing MCE version 2.0 - 26.0.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify in greater detail the approach used in the biopsy.

13. Bilateral Procedure

There are codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The A/B MAC (A) processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the A/B MAC (A) may develop claims prior to payment on a provider-specific basis.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify the exact joint (left or right). Reporting these two more precise ICD-10-PCS codes will clearly indicate if a bilateral procedure is performed.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

15. Invalid Sex

A patient's sex is sometimes necessary for appropriate MS-DRG determination. Usually the A/B MAC (A) can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

16. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate MS-DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

17. Invalid Discharge Date

An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered.

18. Limited Coverage

Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The A/B MACs (A) will handle these procedures as they had previously.

19. Procedure inconsistent with length of stay

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay.

Effective October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

Effective October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

20.2.1.1 - Paying Claims Outside of the MCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

All institutional inpatient claims are routed through the MCE before they are processed to payment. There may be special circumstances, however, when it is necessary to pay claims bypassing MCE edits. The CMS will notify the contractor of these instances. They include:

- New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes timely; and

- Errors are discovered that cannot be corrected timely.

A/B MACs (A) are responsible for reporting problems timely.

20.2.1.1.1 - Requesting to Pay Claims Without MCE Approval

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

The contractor may also request approval from the RO in specific situations to pay claims without first sending them through the MCE. Examples of such situations are:

- A systems error cannot be corrected timely, and the provider's cash flow will be substantially impacted; and/or

- Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal process.

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE

(Rev. 2117, Issued: 12-10-10, Effective: 01-12-11, Implementation: 01-12-11)

Before an inpatient claim may be paid without first going through the MCE, the contractor shall obtain approval from CMS Central Office or the RO.

Note: In certain situations, contractors bypass the MCE through an established, CMS-instructed claim processing procedure (e.g., to verify a facility is certified to perform a specified service after a MCE limited coverage edit is applied). Such scenarios do not require approval from the RO as the approval for such a bypass was inherently implied when the established procedure was first implemented.

In all instances involving payment outside the normal inpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the MCE using the appropriate field in FISS.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor MCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a report of all inpatient claims paid without processing through the MCE with the exception of override situations explained in the Note above (e.g., for limited coverage edits). The list of claims paid outside of the MCE is to include the following information:

    - HIC
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.

20.2.2 - DRG GROUPER Program

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

The A/B MAC (A) pays for inpatient hospital services on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. Each MS-DRG represents the average resources required to care for a case in that particular MS-DRG relative to the national average of resources consumed per case. The MS-DRG weights used to calculate payment are in the Pricer DRGX file.

The A/B MAC (A) uses the GROUPER program to assign the MS-DRG number. GROUPER determines the MS-DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the A/B MAC (A) or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the MS-DRG price. GROUPER input/output are specified below. The A/B MAC (A) determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1. Principal and up to 24 other diagnoses

2. Principal and up to 24 additional procedures

3. Age at last birthday at admission

4. Sex (1=male and 2=female)

5. Discharge destination (patient status code from the claim)

The claim sex coding is M for male and F for female while GROUPER is l for male and 2 for female. Discharge destination codes are similar to claim definitions for patient status except codes 20-29 are summarized as 20. The A/B MAC (A) calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1. Major diagnostic category

2. MS-DRG number

3. Grouper return code (a one position code indicating the action taken by the program)

4. Procedure code used in determining the MS-DRG

5. Diagnosis code used in determining the MS-DRG

6. Secondary diagnosis code used in determining the MS-DRG, if applicable

20.2.3 - PPS Pricer Program
(Rev. 1, 10-01-03)

A3-3615.3, A3-3656.3

The CMS provides a Pricer program to determine the price upon which to base payment under prospective payment. A separate Pricer installation guide is provided. The A/B MAC (A) uses the Pricer appropriate for the date of discharge.

After GROUPER determines the DRG, the A/B MAC (A) 's system calls the Pricer program. Pricer determines the price to pay and prepares a report.

Four data files are included. CMS maintains three:

- DRGX file - contains DRG weights, average length of stay and outlier cutoff points.

- MSAX file - contains urban and rural wage indexes used in calculating payment. CMS may request that the A/B MAC (A) make interim changes to this file when index changes are issued for individual hospitals after issuance of Pricer for the period.

- RATE file - contains census division values and updating amounts used in calculating payment.

The A/B MAC (A) maintains the provider-specific file, (PROV file). This contains information about the facts specific to the provider that affect computations, e.g., effective dates for PPS, type of provider (for application of special computation rules), census division, MSA, adjusted cost per discharge, disproportionate share adjustment percentage, and capital data.

Pricer also calculates the disproportionate share adjustment and adds it to the DRG payment. Correct calculation depends upon the accuracy of related information the A/B MAC (A) includes in the PRICER PROV file.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, provider-specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Pricer uses the Intern-to-Bed ratio in calculating the indirect teaching adjustment for operating costs for the A/B MAC (A) to accumulate and use in related payments. Pricer uses the intern-to-average daily census ratio to calculate the indirect teaching adjustment for capital costs. The A/B MAC (A) ensures that these ratios are available for Pricer to compute payment for teaching hospitals. It includes the ratios in its PROV file to ensure that cost outliers are not overpaid to its teaching hospitals.

Pricer does not calculate utilization days required for the PS&R, CWF, or cost report. It does not determine the amount to pay after deduction for deductible, coinsurance, or the primary payment where Medicare is secondary. The A/B MAC (A) must calculate the price and make adjustments to the price furnished before making payment.

The A/B MACs (A) use the Pricer implementation guide for information concerning Pricer processing reports, input parameters and data requirements.

20.2.3.1 - Provider-Specific File

(Rev. 3836, Issued: 08-18-17, Effective: 11-21-17, Implementation: 11-21-17)

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, 19 and 30 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)

20.3 - Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

(Rev. 2393, Issued: 01-25-12, Effective: 10-01-11, Implementation: 07-02-12)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients.

Adjustments are made in the Federal portion of the operating cost DRG payment to increase payments to hospitals serving a disproportionate share of low-income patients. The additional payment equals the Federal portion of the operating cost DRG payment and outlier payments, but excludes any additional payments for the costs of indirect medical education multiplied by an adjustment percentage.

If a hospital meets the disproportionate share hospital (DSH) definition, an additional operating cost payment will be made for discharges occurring on or after May 1, 1986. The DSH adjustment is applied only to the Federal portion of the operating cost DRG payment (including outlier payments). It is basically a year-end lump sum adjustment. However, the A/B MAC (A) will identify hospitals that are eligible to receive the DSH adjustment and make interim payments subject to a year-end settlement based upon the hospital's DSH percentage for the cost reporting period. The DRG payment a hospital receives includes the interim operating cost DSH payment and an interim operating indirect medical education adjustment.

For services on or after October 1, 1997, the DSH percentage is not applied to outlier payments.

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for IPPS hospitals is located at the following CMS web address:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

The data is used for settlement purposes for hospitals.

Note that CMS issues a Recurring Update Notification prior to the Federal Fiscal Year beginning date to provide contractors with the updated SSI file information.

A. - Regular Calculation of DSH Percentage

The operating DSH percentage is the sum of:

- The percentage of the hospital's total Medicare Part A patient days attributable to Medicare patients who are also SSI recipients (this percentage will be supplied to the A/B MAC (A) by CMS). Since the SSI/Medicare percentages are determined by CMS on a fiscal year basis, hospitals will be afforded the option (for settlement

purposes) of determining their SSI/Medicare percentage based upon data from their own cost reporting period. If a hospital avails itself of this option, it must furnish its FI, in a manner and format prescribed by CMS, data on its Medicare patients for the cost reporting period. CMS will match these data to data supplied by SSA to determine the patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period. The hospital bears the full cost of this process, including the cost of verification by SSA.

Consistent with the regulations at 42 CFR 412.106(b)(2)(i) and 412.106(b)(2)(iii), patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111) which includes Condition Code 04 to their Medicare contractor. This will ensure that these days are included in the hospital's SSI ratio for Fiscal Year 2007 and beyond.

Acute Care hospitals that received DSH during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

For MA patients, Long Term Care Hospitals are also required to submit informational only bills (TOB 111) with Condition Code 04.

For MA patients, Inpatient Rehabilitation Facilities are also required to submit informational only bills (TOB 111) with both Condition Code 04 and the Case Mix Group (CMG) from the IRF PAI. Refer to section 140.2.4.3 for the requirements for Inpatient Rehabilitation Facilities.

(Teaching hospitals do not need to submit additional claims with Condition Code 04 as they already submit claims for Indirect Medical Education for MA beneficiaries with Condition Codes 04 and 69. We will capture SSI information from these claims.)

- The percentage of total patient days attributable to patients entitled to Medicaid, but not to Medicare Part A. (Medicaid days and total days are available on the cost report.)

For operating DSH payments:

For discharges between May 1, 1986, and March 31, 1990, a hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds;
- At least 40 percent for an urban hospital with less than 100 beds; or
- At least 45 percent for a rural hospital, with fewer than 500 beds.

For discharges on and after October 1, 1986, the hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of at least 15 percent, is located in a rural area, and has 500 or more beds.

For discharges between April 1, 1990 and December 31, 1995, a hospital qualifies for an operating DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds;
- At least 40 percent for an urban hospital with fewer than 100 beds;
- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as a sole community hospital; or
- At least 30 percent for a rural hospital with more than 100 beds which is classified as a sole community hospital.

A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a DSH percentage greater than 0.

For the DSH determination, the number of beds in a hospital is determined by counting the number of inpatient care bed days available during the cost reporting period, excluding beds assigned to newborns, custodial care, and PPS excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period. Inpatient care bed days available should be the same as Indirect Medical Education (IME) bed days. Available beds may not match the number of licensed beds.

B. - Determination of Operating DSH Adjustment Percentage

Hospitals that meet the DSH percentage criteria are entitled to adjustments to the Federal portion of their operating cost DRG payments (including the Federal portion of outlier payments) as follows. For hospitals that qualify for DSH payment, Pricer calculates the DSH adjustment percentage. (See §20.2.3.) The following procedures are used to calculate the DSH adjustment.

For the period May 1, 1986 - September 30, 1988:

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds - The lesser of 15 percent or the percentage determined by using the following formula:

(DSH % - 15)(.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21. Its DSH payment factor is computed:

(21 - 15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45. Its DSH payment adjustment factor is computed:

(45 - 15)(.5) + 2.5 = 17.5%

DSH adjustment factor = 15% (.1500) (the maximum adjustment under the law)

- **Urban hospitals with fewer than 100 beds** - 5 percent.
- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period October 1, 1988 - March 31, 1990:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds** - the following formula is used:

  (DSH % - 15) (.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its DSH payment factor is computed:

(21-15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its DSH payment adjustment factor is computed:

(45-15) (.5) + 2.5 = 17.5%

DSH adjustment factor = 17.5% (.1750, the limit was removed effective 10/1/88)

- **Urban hospitals with fewer than 100 beds** - 5 percent.
- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period April 1, 1990 - December 31, 1995:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the following formula is used:

  Through December 31, 1990 - (DSH % - 20.2) (.65) + 5.62

  January 1, 1991, and later - (DSH % - 20.2) (.7) + 5.62

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its December 1990 DSH payment factor is computed:

(21 - 20.2) (.65) + 5.62 = 6.14%

DSH adjustment factor = 6.14% (.0614)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its December 1990 DSH payment adjustment factor is computed:

(45 - 20.2) (.65) + 5.62% = 21.74%

DSH adjustment factor = 21.74% (.2174)

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is equal to or less than 20.2 - the following formula is used:

(DSH % - 15) (.6) + 2.5

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital, and has a DSH percentage of 35 percent. Its DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000)

Hospital D is a rural hospital which is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor is 13% (.1300)

- **Rural hospitals that are RRCs, but are not sole community hospitals**-the following formula is used:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals, but are not RRCs** - 10 percent.

- **Rural hospitals not described above with 100 beds or less** - 4 percent if DSH percentage is 45 percent or more.

- **Rural hospitals not described above with more than 100 beds but fewer than 500 beds** - 4 percent if DSH percentage is 30 percent or more.

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5

For the period October 1, 1993, through September 30, 1994:

- **Urban hospitals with 100 or more beds whose DSH percentage is greater than 20.2**-the following formula is used:

  (DSH % - 20.2) (.8) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5
- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 35 percent. The DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater payment

Hospital D is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

Rural hospitals that are RRCs and are not sole community hospitals - the percentage is determined using the following formula:

(DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

For discharges after September 30, 1994:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the percentage is determined using the following formula:

  (DSH % - 20.2) (.825) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.65) + 2.5

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined with the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 35 percent. Its October 1994 DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater rate

Hospital D is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its October 1994 DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

- **Rural hospitals that are RRCs, but not sole community hospitals** - Use the following formula:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

The amount of the operating cost DSH adjustment is computed by multiplying the Federal portion of the hospital's operating cost DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (.0550). The Federal portion of its DRG revenues including appropriate outlier payments, but excluding any payments for indirect medical education costs, equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

The A/B MAC (A) will accumulate a record of the DSH amount paid, the Federal portion of the operating cost DRG and any outlier amount for hospital discharges after April 30, 1986, to use at cost settlement.

C. - Computation of DSH Adjustment

Compute the amount of the DSH adjustment by multiplying the Federal portion of the hospital's DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (or .0550). The Federal portion of its DRG revenues (including appropriate outlier payments, but excluding any payments for indirect medical education costs) equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

D. - DSH Exception

The law contains a provision whereby a hospital can qualify for an operating cost DSH adjustment of:

- 15 percent for discharges prior to October 1, 1988;
- 25 percent for discharges between October 1, 1988, and April 1, 1990;
- 30 percent for discharges from April 1, 1990, through September 31, 1991;
- 35 percent for discharges on or after October 1, 1991, if:
    - It is located in an urban area and has 100 or more beds; and
    - It demonstrates that, during its cost reporting period, more than 30 percent of its total inpatient care revenues were derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

It is incumbent upon the hospital to demonstrate that more than 30 percent of its total inpatient care revenues are from State and local government sources and that they are specifically earmarked for the care of indigents (that is, none of the money may be used for any purpose other than indigent care). The following are the types of care that are not included as indigent care:

- Free care furnished to satisfy a hospitals Hill-Burton obligation.
- Free care or care a hospital furnished at reduced rates to its employees or by a government hospital to any category of public employee.
- Funds furnished to a hospital to cover general operating deficits.

- The adjustment is not automatic from year to year but must be applied for on an annual basis.

Documentation to support the application includes the hospital's complete audited financial statements and their accompanying notes. The hospital must provide detailed schedules related to State and local revenue appropriations and outline their purpose.

Unless the appropriations are specifically earmarked for indigent patient care, the A/B MAC (A) shall assume that a portion of the funds was intended to cover the costs of other uncompensated care, such as bad debts for non-indigent patients, free care to employees, etc., as well as to cover general operating deficits. The A/B MAC (A) shall calculate the percentage of charity care included in all uncompensated care and apply the percentage to the appropriate funds to determine the amount appropriated for charity care.

Hospitals must submit documentation to support amounts claimed as indigent patient care. This includes a copy of their procedures for determining indigence, steps used to verify a patient's financial information, and methods used to distinguish bad debts from indigence.

The A/B MAC (A) shall review the documentation submitted in support of the provider's request for a disproportionate share adjustment under 42 CFR 412.106(c)(2) of the regulations. Beginning with Federal Fiscal Year (FY) 2011 A/B MACs (A) shall submit to CMS annually by February 28 documentation for the hospitals they determine meet the qualifying standards for receiving disproportionate share hospital (DSH) payments under section 42 CFR 412.106(c)(2). This review can be accomplished in conjunction with the audit/settlement of the cost report for the period subject to the adjustment. At a minimum, the A/B MAC (A) shall:

- Verify total inpatient revenues;
- Verify that State and local government appropriations on the financial statements are consistent with amounts contained in governmental appropriations bills;
- Review, on the basis of a sample of cases, the provider's implementation of procedures for identifying indigent patients. Ensure that amounts for "indigent" patients do not include charges associated with:
    - Titles XIX and XVIII patient care;
    - Hill-Burton care;
    - Free care to employees; and
    - Bad debts for patients who are not indigent.

E. - Reporting for PS&R and CWF

The A/B MAC (A) 's PPS Pricer identifies the amount of the DSH adjustment on each bill. The A/B MAC (A) reports this amount with value code 18 to its PS&R, and to CWF.

20.3.1 - Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation
(Rev. 1, 10-01-03)

20.3.1.1 - Clarification for Cost Reporting Periods Beginning On or After January 1, 2000
(Rev. 1, 10-01-03)

PM A-01-03

Under §1886(d)(5)(F) of the Social Security Act (the Act), the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid

enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the A/B MAC (A) must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. Please see the chart in 140.2.4.1, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted.

20.3.1.2 - Hold Harmless for Cost Reporting Periods Beginning Before January 1, 2000
(Rev. 1, 10-01-03)

In accordance with the hold harmless position communicated by CMS on October 15, 1999, for cost reporting periods beginning before January 1, 2000, hospitals are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or

demonstration population days in the Medicaid days factor used in the Medicare DSH formula. This is consistent with CMS' determination that hospitals and A/B MACs (A) relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or A/B MACs (A). Although CMS has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue

In practical terms this means that the A/B MAC (A) is not to reopen any cost reports for cost reporting periods beginning before January 1, 2000, to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports. If, prior to the issuance of this Program Memorandum, a hospital reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts (including interest) collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance. Furthermore, on or after October 15, 1999, the A/B MAC (A) is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

For cost reporting periods beginning before January 1, 2000, hospitals are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999, (i.e., for open cost reports, the A/B MAC (A) allows only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, the A/B MAC (A) is to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days that the A/B MAC (A) allows for the open cost reports must be supported by auditable documentation provided by the hospital.

Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue

If a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, the A/B MAC (A) is not to pay the hospital based on the inclusion of these types of days for any open cost reports for cost reporting periods

beginning before January 1, 2000. Furthermore, on or after October 15, 1999, the A/B MAC (A) is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, the A/B MAC (A) will reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. If there are any questions or concerns regarding the qualifications for a "jurisdictionally proper appeal," the A/B MAC (A) submits them in writing before rendering a decision in a specific case to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Office of Financial Management
Financial Services Group
Location C3-14-16
Baltimore, Maryland 21244-1850.

Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that are used in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

Continue to pay the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

Finally, if a hospital has filed a jurisdictionally proper appeal with respect to the CMS 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the CMS 97-2 appeal.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.	No.
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan.	No.
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No.
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes.
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes.
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
§1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes.
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes.
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.	Yes.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No.

20.3.1.3 – Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009

(Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

Observation Days

For cost reporting periods beginning on or after October 1, 2009, observation days for patients later admitted as an inpatient will no longer be included in the Medicare disproportionate patient percentage (DPP). In addition, observation bed days for patients later admitted as an inpatient will no longer be counted towards a hospital's available bed day count for DSH and IME. Between October 1, 2003, and October 1, 2009, hospitals had reported on their cost report the Medicaid observation patient days for admitted patients and total observation patient days for admitted patients for inclusion in the Medicaid fraction of the Medicare DPP, and for the determination of the available bed day count for DSH and IME. However, effective for cost reporting periods beginning on or after October 1, 2009, observation patient days are no longer included in the DPP, and observation bed days will no longer be counted towards the available bed day count for DSH or IME.

Labor and Delivery Patient Days

For cost reporting periods beginning on or after October 1, 2009, we will include in the Medicare disproportionate patient percentage (DPP) patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a "maternity suite" in which labor, delivery, recovery and postpartum care all take place in the same room. Prior to October 1, 2009, patient days associated with beds used for ancillary labor and deliver were not counted in the DPP. However, for cost reporting periods beginning on or after October 1, 2009, but before cost reporting periods beginning on or after October 1, 2012, if a patient, admitted to the hospital as an inpatient, occupies an ancillary bed for labor and delivery, the patient days associated with the ancillary labor/delivery services will be counted in the DPP. For cost reporting periods beginning on or after October 1, 2009 but before cost reporting periods beginning on or after October 1, 2012, this policy applies only to counting patient days, and does not change the policy of determining the number of available beds in 42 CFR 412.106(a). Beds associated with ancillary labor/delivery services are not included in the available bed day count.

Reporting Inpatient Days in the Numerator of the Medicaid Fraction

Hospitals can report days in the numerator of the Medicaid fraction by one of three methodologies. For cost reporting periods beginning on or after October 1, 2009, hospitals can report Medicaid-eligible days based on date of discharge, date of admission, or dates of service. A hospital is required to notify CMS (through the fiscal intermediary or MAC) in writing if the hospital chooses to change its methodology of counting days in the numerator of the Medicaid fraction. The written notification should be submitted at least 30 days prior to the beginning of the cost reporting period to which the change would apply. The written notification must specify the changed methodology the hospital wishes to use and the cost reporting period for which the methodology would apply. The change in methodology would be effective on the first day of the specified cost reporting period for the entire cost reporting period. The change would be effective for all future cost reporting periods unless the hospital submits a subsequent written notification to change its methodology.

20.3.1.4 – Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2012

(Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

Labor and Delivery Bed Days

Effective for cost reporting periods beginning on or after October 1, 2012, we will include bed days associated with ancillary labor/delivery services to determine the number of beds in 42CFR412.105(b), which is cross-referenced in 42 CFR412.106(a)(1)(i) for the purposes of determining the DSH payment adjustment. Bed days associated with ancillary labor/delivery services will be included to determine the number of beds for DSH and IME. For cost reporting periods beginning before October 1, 2012, bed days associated with ancillary labor and delivery services were not counted in the available bed day count for DSH and IME.

20.3.2 - Updates to the Federal Fiscal Year (FY) 2001

(Rev. 1, 10-01-03)
PM A-01-47

20.3.2.1 - Inpatient Hospital Payments and Disproportionate Share Hospital (DSH) Thresholds and Adjustments

(Rev. 1, 10-01-03)

The new FY 2001 operating standardized amounts are effective April 1, 2001, as required by §301 of BIPA 2000 (P.L. 106-554), and the new DSH thresholds and adjustments are required by §211 of BIPA 2000. In conjunction with the new standardized amount, the new capital rates and outlier adjustment factor thresholds are effective April 1, 2001.

The following standardized amounts effective for discharges occurring on or after April 1, 2001, and before October 1, 2001, are:

Final FY 2001 Operating Rates

Designation	Large Urban Areas	Large Urban Areas	Other Areas	Other Areas
	Labor-Related	**Nonlabor-Related**	**Labor-Related**	**Nonlabor-Related**
+National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	$2,900.64	$1,179.02	$2,900.64	$1,179.02
Puerto Rico	$1,402.79	$564.66	$1,380.58	$555.72
SCHs	$2,895.02	$1,176.74	$2,849.20	$ 1,158.11

Final FY 2001 Capital Rates

National	$380.85
Puerto Rico	$184.61

Due to the changes to the standardized amounts, CMS recalculated the fixed loss cost outlier threshold applicable for discharges on or after April 1, 2001, and before October 1, 2001. The new thresholds are equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs).

In addition, §211 of BIPA 2000 revised the thresholds by which certain classes of hospitals qualify for the disproportionate share adjustment, effective for discharges occurring on or after April 1, 2001. Section 211 also revised the adjustment computations for these hospitals.

The specific changes are identified below.

Hospital Type	Qualifying DSH Percent	Adjustment Computation
Urban Hospitals		
0-99 Beds	≥15%, <19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15)] 5.25%
100+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	≥15%, <19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 10%
Rural Referral Centers (RRC)	≥15%,<19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 5.25% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	≥15%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-499Beds	≥15%,<19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
500+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct. -20.2%)]

These new rates as well as changes to the DSH adjustments are incorporated into Pricer 01.2. The formulas are spelled out in the statute.

20.3.3 – Prospective Payment Changes for Fiscal Year (FY) 2003

(Rev. 1, 10-01-03)
A-02-084

The PPS changes for FY2003 were published in the Federal Register on August 1, 2002. All changes are effective for hospital discharges occurring on or after October 1, 2002, unless otherwise noted.

ICD-9-CM coding changes are effective October 1, 2002. The new ICD-9-CM codes are listed, along with their diagnosis-related group (DRG) classifications in Tables 6a and 6b in the final rule for PPS changes for FY 2003. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f of the same final rule. GROUPER 20.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2002. Medicare Code Editor (MCE) 19.0 and Outpatient Code Editor (OCE) versions 18.0 and 3.20 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2002.

Additional changes for FY 2003 are:

- The standardized amount update factor is 2.95 percent for all hospitals.
- The hospital specific update factor is 2.95 percent for all hospitals.

- The common fixed loss cost outlier threshold in FY 2003 is equal to the PPS rate for the DRG, Indirect Medical Education (IME), and Disproportionate Share Hospital (DSH) plus $33,560.

- The marginal cost factor for cost outliers remains 80 percent.

- The 2003 Federal capital rate is $407.01 and the Puerto Rico capital rate is $198.29.

- The FY 2003 outlier adjustment factor is 0.948999 for the operating standardized amount.

- The FY 2003 outlier adjustment factor for Puerto Rico is 0.981651 for the operating standardized amount. Also new for FY 03, there is an outlier adjustment factor of 0.965325 for operating national/Puerto Rican blend.

- Payments under the DSH provision are not reduced in FY 2003.

- The IME formula is 1.35*[(1+ resident-to-bed ratio)**. 405-1] for FY 2003.

- The revised hospital wage indexes and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the PPS final rule.

- Grouper 20.0 and MCE 19.0 for discharges occurring on or after October 1, 2002 replace earlier versions of the software.

See Addendum: Hospital Reclassifications and Redesignations by Individual Hospital - FY2003.

20.3.4 – Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond

(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

The IPPS changes for FY 2004 were published in the Federal Register on August 1, 2003. All changes are effective for hospital discharges occurring on or after October 1, 2003. Additional changes were listed in a Correction Notice to the Federal Register on October 6, 2003, and a One Time Notification (Pub. 100-20, Transmittal 16, published on October 31, 2003).

Fiscal year changes to the inpatient prospective payment system occur every October. Specific instructions will be published shortly after the publication of the IPPS Final Rule each year. In addition, other changes to the inpatient prospective payment system may occur in January, April or July as necessary.

20.4 - Hospital Capital Payments Under PPS

(Rev. 1, 10-01-03)

A3-3611

The Omnibus Budget Reconciliation Act of 1987 established an effective date of October 1, 1991, for capital PPS. Capital PPS will pay hospitals a fixed amount for each Medicare admission upon completion of a 10-year transition period.

Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs. They continue to be paid for capital-related costs on a reasonable cost basis.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to PPS for operating costs. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines in §§40, also apply to capital PPS payments. Outlier thresholds and computation methods have been combined effective with FY 1993 for operating and capital costs.

Capital transfer cases are paid on a per diem basis analogous to the manner in which operating PPS payments are made for transfer cases.

Beneficiary deductible and coinsurance obligations do not apply to capital costs. Ancillary costs paid under Part B do not impact capital PPS payments. The 10-year transition period was established to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. These high capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national rate for those hospitals with capital obligations that are less than the national rate.

A combined payment is made for both operating costs and capital costs under PPS, but the value of the payment for each must be separately identified in the remittance advice for accounting purposes.

20.4.1 - Federal Rate
(Rev. 1, 10-01-03)

A3-3611.1

The standard Federal capital payment for FY 1992 and later years is based on the projected national average Medicare capital costs per discharge for each of the fiscal years. The Federal rate is adjusted for each hospital's case mix, day and cost outliers and wage index location. A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a disproportionate share (DSH) percentage greater than 0.

The Federal rate is adjusted annually to reflect changes in these factors.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. The A/B MAC (A) calculates the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the CMS Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the cost reporting period.) It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting

period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.2 - Hold Harmless Payments
(Rev. 1, 10-01-03)

A3-3611.2

In FY 1992, hospitals with a hospital-specific rate for capital that is above the Federal PPS rate for the cost reporting period that ended in FY 1990 can receive the higher of:

- The hold harmless-old capital rate, which is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital (see §20.4.5 for the definitions of old and new capital); or

- The hold harmless - 100 percent Federal rate.

The A/B MAC (A) adjusts the hospital-specific rate in the cost report for the period ending in FY 1990 for case mix. It updates the rate to FY 1992 levels using the projected increase in national average capital costs per discharge to initially determine whether a hospital should be paid under the hold harmless or the fully prospective methodology. The type of methodology is entered in the provider-specific file. (See §20.2.3.)

Hospitals paid under the fully prospective methodology may change to the hold harmless methodology if justified by the addition of obligated capital and other changes in remaining old capital costs subsequent to the base period. This option is available through the later of a hospital's cost reporting period beginning in FY 94 or after obligated capital has been put in use. Hospitals must request an extension from the A/B MAC (A) by the later of January 1, 1993, or within 180 days of the event causing the delay, if they will be unable to put an asset in use for inpatient care by October 1, 1996. The new hospital-specific rate reflects the disposal of old assets and the addition of obligated capital costs, but not new capital acquisitions. If the recalculated hospital-specific rate exceeds the Federal rate, the hospital will be paid under the hold harmless methodology. The payment methodology in effect for FY 94 (or after the obligated capital has been put in use, if later) determines the payment methodology applicable for the remainder of the transition period under either transition payment methodology.

The A/B MAC (A) does not hold harmless a hospital for increased costs resulting from a lease arrangement entered into after December 31, 1990.

If a hospital has such low Medicare utilization in its original capital base period that it is not required to file a cost report, its hospital-specific rate will be based on its old capital costs per discharge in the first 12-month cost reporting period for which a cost report is filed.

The A/B MAC (A) converts a reasonable cost/hold harmless hospital to the 100 percent Federal payment rate when:

- Advantageous due to reductions in depreciation and/or the allowable percentage of old capital;

- A hospital elects to be paid at 100 percent of the Federal rate; or
- A hospital does not maintain adequate records to identify its old capital related costs.

The A/B MAC (A) enters the payment methodology change in the provider-specific file.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. The A/B MAC (A) calculates the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the CMS Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the cost reporting period). It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.3 - Blended Payments
(Rev. 1, 10-01-03)

A3-3611.3

Hospitals with a FY 1990 hospital-specific rate for capital below the Federal rate are paid a fully prospective capital rate based on a blend of their hospital-specific rate and the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1992 is based on a blend of 90 percent of the hospital-specific rate and 10 percent of the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1993 is based on a blend of 80 percent of the hospital-specific rate and 20 percent of the Federal rate. The Federal portion of the payment increases by 10 percent each year and the hospital-specific portions decreases by 10 percent each year, culminating in payment at 100 percent of the Federal rate in the tenth year.

20.4.4 - Capital Payments in Puerto Rico
(Rev. 1, 10-01-03)

A3-3611.4

A special standard rate applies to Puerto Rico. It is a combination of 50 percent of the Federal capital amount and 50 percent of the Puerto Rican capital amount. It is used in lieu of the Federal rate to compute hold harmless and fully prospective payments for PPS hospitals in Puerto Rico.

20.4.5 - Old and New Capital
(Rev. 1, 10-01-03)

A3-3611.5

Old capital is a hospital asset that:

- Has been put in use for patient care on or before December 31, 1990; or

- Has been legally committed to by an enforceable contract entered into on or before December 31, 1990, and put in patient use before October 1, 1994.

All other assets are considered new for Medicare purposes.

20.4.6 - New Hospitals
(Rev. 1, 10-01-03)

A3-3611.6

New hospitals that open during the national 10-year transition are exempt from capital PPS payment for their first two years of operation. A new hospital is one that does not have a 12-month cost reporting period that ended on or before September 30, 1990. The new hospital exemption does not apply to:

- A new acute care hospital that operated as a PPS excluded hospital for 2 or more years before its transition to PPS;

- A hospital which has been open more than 2 years, but has participated in Medicare fewer than 2 years;

- A hospital that closes and reopens within 2 years under the same or different ownership; or

- A hospital that builds a new or replacement facility at the same or a new location, even if a change of ownership or new leasing arrangements are involved.

A new hospital is paid 85 percent of its reasonable costs for capital during the exemption period. The hospital's second year of operation is the base period for determination of the hospital-specific rate and old capital assets. Effective with its third year of operation, the hospital is paid:

- The fully prospective methodology if the hospital-specific rate is less than the Federal rate. The A/B MAC (A) uses the blend rate applicable to the Federal FY in which the base period begins. For example, a new hospital with a hospital-specific rate less than the Federal rate and a base year beginning in FY 1995 is paid 70 percent of its hospital-specific rate and 30 percent of the Federal rate; or

- The hold harmless methodology if the hospital-specific rate is greater than the Federal rate. Hold harmless payments may continue for up to 8 years. They may continue beyond the first cost reporting period that begins on or after October 1, 2000.

20.4.7 - Capital PPS Exception Payments
(Rev. 1, 10-01-03)

A3-3611.7, 42 CFR 412.348

Exception payments are provided for hospitals with inordinately high levels of capital obligations. Payment is made to a hospital paid under either the fully prospective payment

methodology, or the hold-harmless payment methodology. Exception payments will expire at the end of the 10-year transition period. Exception payments ensure that:

- Sole community hospitals receive 90 percent of their Medicare inpatient capital costs;
- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and
- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

Pricer adds interim exception payments to the basic capital payment, using the rate entered in positions 189-194 of the provider-specific file. The A/B MAC (A) adjusts these interim payments, as needed, at cost report settlement.

A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount.

A limited exception is also provided during the 10-year transition period for hospitals that experience unanticipated extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) to qualify for this exception. An eligible hospital's minimum payment level under this exception is 85 percent of costs associated with the unanticipated capital expenditure and the applicable minimum payment level for its other Medicare inpatient capital costs.

Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

These limited exceptions must be approved by CMS prior to payment. If approved, the A/B MAC (A) includes the limited exception payment amount per discharge in the exception field of the provider specific file.

20.4.8 - Capital Outliers
(Rev. 1, 10-01-03)

A3-3611.8

Total Federal PPS payments are reduced by an amount equal to anticipated outlier payments for the year to fund capital and operating outlier payments. Outlier payments apply only to the Federal portions of capital payments. Pricer calculates outlier payments.

Pricer used a combined methodology to determine the day outlier payment rate for capital and operating day outliers (**Day outliers were eliminated after FY 1997**). A second combined methodology is used to determine the cost outlier payment rate for capital and operating costs. A capital or operating cost outlier is paid only if both capital and operating

costs related to an admission exceed the combined outlier threshold. Pricer pays the higher of the combined total cost outlier payment or the total day outlier payment. An exception applies to a transferring hospital. A transferring hospital may be paid a cost outlier, but may not be paid a day outlier unless DRG 385 or 456 applies. The outlier computation methodology is contained in the A/B MAC (A) Pricer installation guide. (See §20.7 for the common thresholds that apply to both operating and capital outliers.)

20.4.9 - Admission Prior to and Discharge After Capital PPS Implementation Date
(Rev. 1, 10-01-03)

A3-3611.9

The capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS. The A/B MAC (A) may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period.

It bases any outlier payment due on the entire stay, not only that portion of the stay that began after the start of capital PPS.

20.4.10 - Market Basket Update
(Rev. 1, 10-01-03)

A3-3611.10

For FY 1992 through FY 1995, the update to the Federal and the hospital-specific rates is based on actual increases in capital-related costs per discharge adjusted for case mix change. For example, FY 1993 rate updates are based on a comparison of inpatient capital costs per case in Medicare cost reports beginning in FY 1990 and the costs per case in the cost reports beginning in FY 1988. The update computation will be modified after FY 1995 to reflect the capital market basket index, changes in capital requirements and new technology. Annual updates for periods after FY 1992 will be effective October 1 for all PPS hospitals, rather than the start of cost report periods that begin during that FY.

20.5 - Rural Referral Centers (RRCs)
(Rev. 1, 10-01-03)

A3-3610.16, HO-415.17

Section 1886(d)(5)(C) of the Act provides for exceptions and adjustments to the standardized prospective payment amounts to take into account the special needs of RRCs. The adjustment allowed for approved RRCs is that they are paid based upon the urban, rather than rural, prospective payment rates as adjusted by the applicable DRG weighting factor and the rural area index. In addition, OBRA 89 (P.L. 101-239) extended RRC status through cost reporting periods beginning before October 1992 to any hospital classified as an RRC as of September 30, 1989.

To retain status as an RRC effective with the cost reporting period beginning on or after October 1, 1992, a hospital must have met the criteria for classification as an RRC in at least two of the prior three years, or qualify on the basis of the requirements for initial RRC certification for the current year. The A/B MAC (A) will not review the RRC status of a hospital before the end of its third full cost reporting year as an RRC. It will limit review of RRCs in operation more than three years at the beginning of FY 1993 to a hospital's most recent three years. RRCs that pass review as meeting RRC status for at least two of the last three years receive a 3-year extension of their RRC status.

The rates in Pricer include a reduction in the adjusted standardized amounts for all hospitals to ensure that total PPS payment neither increase nor decrease as a result of the increase in payments to RRCs.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 1992, a rural hospital must have had at least 275 beds, or the hospital must have met one of three criteria in 42 CFR 412.96(c) (3), (4) and (5), and both of the following requirements:

- The hospital's case-mix index value for FY 91 must have been at least 1.2760, or equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located, if fewer.

- For its cost reporting period that began during FY 1991, the hospital must have had at least 5000 discharges, or equal to the median number of discharges for urban hospitals in that census region, if fewer, or if an osteopathic hospital, must have had at least 3000 discharges.

The CMS publishes the median case-mix index value and the median number of discharges annually in the PPS update in the "Federal Register."

20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. - Criteria for Sole Community Hospitals (SCHs)

A sole community hospital (SCH) is a hospital that is paid under the Medicare hospital inpatient prospective payment system (IPPS) and is either located more than 35 miles from other like hospitals or is located in a rural area, and meets the criteria for SCH status as specified at 42 CFR 412.92 (Title 42 of the Code of Federal Regulations, Section 412.92, Special treatment: Sole community hospitals). A hospital may be designated as an SCH effective with cost reporting periods beginning on or after October 1, 1990.

B. - Criteria for Medicare Dependent Hospitals (MDHs)

A Medicare-dependent, small rural hospital (MDH) is a hospital that is paid under the Medicare hospital inpatient prospective payment system (IPPS) and meets the criteria for MDH status as specified at 42 CFR 412.108 (Title 42 of the Code of Federal Regulations, Section 412.108 Special treatment: Medicare-dependent, small rural hospitals). A hospital may be designated as an MDH effective with cost reporting periods beginning on or after

April 1, 1990, and ending on or before March 31, 1993, and for discharges occurring on or after October 1, 1997, and before October 1, 2011.

C. - Payment to SCHs and MDHs

SCHs and MDHs are paid based on either the Federal rate or their hospital-specific (HSP) rate, whichever will result in the greatest payment. The HSP rate is the hospital's rate based on their updated costs per discharge for a particular fiscal year (FY) as specified in statute. Like all IPPS hospitals paid, SCHs and MDHs are paid for their discharges based on the diagnosis-related DRG classification and weights regardless of whether payment based on the Federal rate or the hospital's HSP rate results in the greatest payment.

SCHs will be paid based on their HSP rate for either FY 1982, 1987, 1996 (for cost reporting periods beginning on or after October 1, 2000) or 2006 (for cost reporting periods beginning on or after January 1, 2009) if this results in a greater payment than the Federal rate. For more detail, see 42 CFR 412.92(d) and 42 CFR 412.73, 412.75, 412.77, and 412.78, respectively, for determining the HSP rates for FYs 1982, 1987, 1996 and 2006.

MDHs will be paid based on their HSP rate for either FY 1982, 1987, or 2002 (for cost reporting periods beginning on or after October 1, 2006) if this results in a greater payment than the Federal rate. For more detail, see 42 CFR 412.108(c) and 42 CFR 412.73, 412.75, and 412.79, respectively, for determining the HSP rates for FYs 1982, 1987, and 2002.

In addition, qualifying SCHs and MDHs that experience a significant decrease in its number of discharges may receive an additional payment as specified at 42 CFR 412.92(e) and 42 CFR 412.108(d), respectively.

In general, the HSP rates for both SCHs and MDHs are updated annually. The HSP rates are updated for inflation by the applicable market basket increase for each FY after the base period year, and are also adjusted by a budget neutrality factor to account for the annual DRG reclassification and recalibration for each year from FY 1993 forward, regardless of the year of the base period. (For reference purposes, the budget neutrality adjustment factors are listed below at the end of this section.) For the inflation update, beginning FY 2005, if the hospital did not submit quality data, the market basket update is reduced by a percentage specified in statute for the applicable FY consistent with section 1886(b)(3)(B)(viii) of the Act.

Applicable Fiscal Year	Budget Neutrality Adjustment Factors
1993	0.999851
1994	0.999003
1995	0.998050
1996	0.999306
1997	0.998703
1998	0.997731
1999	0.998978
2000	0.997808
2001	0.997174
2002	0.995821
2003	0.993111

Applicable Fiscal Year	Budget Neutrality Adjustment Factors
2004	1.002608
2005	0.999876
2006	0.998993
2007	0.997395
2008	0.995743
2009	0.998795
2010	0.997941

D. - Claims Processing

The Qualifying DSH Percent uses the following provider type codes to enable Pricer to calculate the appropriate rates for these facilities:

- 14 for a MDH that is not an RRC;
- 15 for a MDH that is also an RRC;
- 16 for a rebased SCH that is not an RRC; and
- 17 for a rebased SCH that is also an RRC.

The A/B MAC (A) calculates the HSP rate and determines the greatest HSP rate (for SCHs, FY 1982, 1987, 1996 or 2006; for MDHs, FY 1982, 1987 or 2002). Then the A/B MAC (A) updates the HSP rate to the applicable FY and enters that amount in the PPS Facility Specific Rate of the Provider-Specific File (PSF), for the applicable effective date. The HSP rate is to be entered even if the Federal rate is expected to result in higher payments than the applicable HSP rate. Preloading the applicable HSP rate before the effective date is acceptable as long as the correct effective date is used for the PSF record. The A/B MAC (A) leaves the field blank if the hospital was not in operation during any of the applicable HSP base years.

Pricer will calculate the payment based on the higher of the Federal rate or the HSP rate. Where the HSP rate is higher, Pricer reports the amount of the difference in the hospital-specific field. The A/B MAC (A) carries this amount forward in the hospital-specific payment field to its PS&R record for use at cost settlement.

20.7 - Billing Applicable to PPS
(Rev. 1, 10-01-03)

20.7.1- Stays Prior to and Discharge After IPPS Implementation Date
(Rev. 1, 10-01-03)

A3-3610.4, HO-415.7

When the admission is before the hospital's PPS effective date and the discharge is later than that date (transition claims), the Medicare payment for the period before PPS is on a reasonable cost basis and the payment for the period after PPS is on a DRG basis.

The hospital must submit two bills. The first bill is for the period before the PPS effective date and is processed and paid in accordance with requirements in effect before the hospital's PPS effective date. The second bill is processed under PPS but the amount of payment on the first bill is subtracted from it. A/B MACs (A) make the adjustment by subtracting the interim payment from the prospective payment (before any deduction for deductible or coinsurance) for the inpatient operating costs applicable to the days in the prior period. The interim payment applicable to the prior period is adjusted to exclude estimated costs related to capital and direct medical education, kidney acquisition costs, and for bad debts for uncollectible deductible and coinsurance. A/B MACs (A) will make an estimate if necessary.

For hospitals previously receiving interim payment on the basis of an average cost per diem or under PIP, the A/B MAC (A) determines and removes a per diem amount for the excluded costs for that period from the interim payments before reducing the prospective payment amount applicable to the discharge in the subsequent period under PPS. Similarly, for hospitals that received a percentage of billed charges, the portion of the percentage applicable to the excluded cost items is removed. The net percentage to the charges billed in the prior period (cut-off bill) is applied. The resulting amount is subtracted from the PPS payment applicable to the discharge in the subsequent period.

For transition claims, payment must not exceed the higher of what would have been paid under PPS including the outlier adjustment **or** any earlier cost payment. The final amount is not reduced to less than zero. No further adjustments are appropriate.

The interim payments used to reduce the prospective payment amounts are considered to represent fairly the inpatient operating costs incurred and fair payment for the portion of the stay occurring in the prior period. Therefore, the adjustment is final and not subject to further modification.

On bills covering two cost reporting periods:

- Each bill includes charges and covered days that apply to the period covered.
- The cut-off bill for the cost period is completed per Chapter 25.
- The PPS bill contains principal diagnosis and surgical procedures for the entire stay.
- The PPS bill shows the admission date, but the period covered begins with the first day of the new accounting year.
- Where discharge is on the first day of the new accounting year, a PPS bill is still due. Some payment may be due the provider, and the open admission must be closed on CMS' records. There are no accommodation charges on the day of discharge; the hospital will report ancillary charges for the day of discharge on the prior bill.
- Coinsurance days and related amounts are applied separately to each bill, i.e., the proper deduction for coinsurance days reported on the second bill is taken from that bill.

20.7.2 - Split Bills

(Rev. 1, 10-01-03)

A3-3610.6, HO-415.9

Under PPS, split billing is not needed for cost reporting purposes; however, it is necessary to show on the bill the coinsurance days in each calendar year for proper application of the coinsurance amount.

For admissions prior to the cost reporting year under IPPS with a discharge after the beginning of the prospective payment year, the DRG payment for the discharge is reduced by the cost of services furnished in the prior period.

The hospital uses the day or charge statistics on the bill representing the portion of the stay in the prior period to determine the cost of the services furnished. Split bills are not needed at the end of the government's fiscal year or the calendar year as changes in DRG prices are determined by the date of discharge. This is shown in value codes 09 (first year coinsurance) and 11 (second year coinsurance). (See Chapter 25.)

PPS days on the cost report are allocated to the year of the discharge. Hospitals not on IPPS, LTCHPPS, or IRFPPS continue to submit split bills at the end of their fiscal years and allocate the days to the hospital year in which they occurred.

When split billing applies, DRG payments are made only on bills that show a discharge date and status. No DRG payment is made on PPS bills that show "still patient" status.

The hospital may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period. Capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS.

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factors furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood-clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

A/B MACs (B) shall process non-institutional blood clotting factor claims.

The A/B MACs (A) shall process institutional blood clotting factor claims payable under either Part A or Part B.

A. - Inpatient Bills

Under the Inpatient Prospective Payment System (IPPS), hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider under special instructions for units of service.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Shared System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2004, this payment is based on 95 percent of average wholesale price.) For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For SNF inpatient Part A, there is no add-on payment for blood clotting factors.

The codes for blood-clotting factors are found on the Medicare Part B Drug Pricing File. This file is distributed on a quarterly basis.

For discharges occurring on or after October 1, 2000, and before December 31, 2005, report HCPCS Q0187 based on 1 billing unit per 1.2 mg. Effective January 1, 2006, HCPCS code J7189 replaces Q0187 and is defined as 1 billing unit per 1 microgram (mcg).

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE 1

HCPCS	Drug	Dosage
J7189	Factor VIIa	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	Drug	Dosage
J9355	Trastuzumab	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	Drug	Dosage
J3100	Tenecteplase	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

At times, the facility provides less than the amount provided in a single use vial and there is waste, i.e.; some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus the amount administered.

Example 1:

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2:

An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and

repeats the HCPCS code. One hundred thousand fifty (100,050) units are reported on one line as 99,999, and another line shows 1,051.

Revenue Code 0636 is used. It requires HCPCS. Some other inpatient drugs continue to be billed without HCPCS codes under pharmacy.

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is also applicable to inpatient Part B services in SNFs and all types of hospitals, including CAHs. Separate payment is not made to SNFs for beneficiaries in an inpatient Part A stay.

B. - A/B MAC (A) Action

The contractor is responsible for the following:

- It accepts HCPCS codes for inpatient services;
- It edits to require HCPCS codes with Revenue Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. It does not edit units except to ensure a numeric value;
- It reduces charges forwarded to Pricer by the charges for hemophilia clotting factors in revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF; and
- It modifies data entry screens to accept HCPCS codes for hospital (including CAH) swing bed, and SNF inpatient claims (bill types 11X, 12X, 18x, 21x and, 22x).

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if diagnosis code for hemophilia is included on the bill.

Inpatient blood-clotting factors are covered only for beneficiaries with hemophilia. One of the following hemophilia diagnosis codes must be reported on the claim for payment to be made for blood clotting factors.

Table 1 - Effective for discharges September 1 1993 through the implementation of ICD-10

ICD-9-CM code	Description
286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI deficiency
286.3	Congenital deficiency of other clotting factors
286.4	von Willebrands' disease

Table 2 - Effective for discharges August 1, 2001 through the implementation of ICD-10, payment may be made if a diagnosis codes from either Table 1 or Table 2 is reported is reported:

ICD-9-CM code	Description
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants (terminate effective September 30, 2011)
286.7	Acquired coagulation factor deficiency

Table 3 - Effective for discharges on October 1, 2011, through the implementation of ICD-10 payment may be made if a diagnosis code from any of Table 1, Table 2 or Table 3 is reported:

ICD-9-CM code	Description
286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Effective for discharges on or after the implementation of ICD-10-CM, the following codes are applicable, and payment may be made for blood clotting factors only if a hemophilia code from the range D66 - D68.4 is reported

A crosswalk of ICD 9 to ICD10 hemophilia diagnosis codes follows:

ICD-9-CM Code	Description	ICD-10-CM Code	Description
286.0	Congenital factor VIII disorder	D66	Hereditary factor VIII deficiency
286.1	Congenital factor IX disorder	D67	Hereditary factor IX deficiency
286.2	Congenital factor XI deficiency	D68.1	Hereditary factor XI deficiency
286.3	Congenital deficiency of other clotting factors	D68.2	Hereditary deficiency of other clotting factors
286.4	von Willebrands' disease	D68.0	Von Willebrand's disease
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants (terminate	N/A	

ICD-9-CM Code	Description	ICD-10-CM Code	Description
	effective September 30, 2011)		
286.52	Acquired hemophilia	D68.311	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder	D68.312	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors	D68.318	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
286.7	Acquired coagulation factor deficiency	D68.32	Antiphospholipid antibody with hemorrhagic disorder
286.7	Acquired coagulation factor deficiency	D68.4	Acquired coagulation factor deficiency

C. - Part A Remittance Advice

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add On is included in the overall claim payment (Provider Reimbursement, CLP04).

If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM. The Hemophilia Add On amount will always be included in the CLP04 Claim Payment Amount.

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier PLB) segment with the provider level adjustment reason code HM. For remittances reporting PIP payments, the sum of inpatient claims, CLP04, is backed out at PLB with PI/PA. If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM.

D. - Standard Hard Copy Remittance Advice

For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

The following reflects the remittance advice messages and associated codes that will appear when processing claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: OA
CARC: 94
RARC: MA103

MSN: N/A

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ASC X12 835 remittance advice, where additional information is available.

See chapter 22, for detailed instructions and definitions.

20.7.4 - Cost Outlier Bills With Benefits Exhausted
(Rev. 1, 10-01-03)

PM - A-99-17 (CR-749)

Providers under IPPS, LTCH PPS, and IRF PPS follow this scenario when benefits are exhausted.

The methodology for using benefit days and reimbursing cost outliers is based on the beneficiary having a lifetime reserve (LTR) benefit day which the beneficiary elects to use or a regular benefit (regular or coinsurance) day beginning the day after the day covered charges are incurred in an amount that results in a cost outlier payment for the provider. Additional charges are considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

DRG claims with cost outlier payments with discharge dates on or after October 1, 1997, must have an Occurrence Code (OC) 47 on the claim unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during Occurrence Span Code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76, or 79 dates. Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available per CWF inquiry or their FI.

Any nonutilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be identified using OSC 70. LTR days should be used as necessary and as elected by the beneficiary. If coinsurance days are exhausted during the inlier portion of the stay and there is a period of nonutilization indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown. When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted. Covered charges should be accrued to reflect the entire period of the bill if the bill is fully

covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted.

Assumptions for all of the following examples:

1. Cost outlier threshold amount is $50,000.

2. Threshold amount is reached on the 25th day.

3. Billed charges are $1,000 each day thereafter.

4. Beneficiary elects to use any available LTR days.

EXAMPLE 1: LTR Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available	30 LTR
Covered days	30
Noncovered days	0
Cost report days	30

All charges for Medicare approved revenue codes billed as covered
No OC 47 needed

Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges

EXAMPLE 2: LTR Days Exhaust in the Cost Outlier

Dates of service:	1/1 - 2/10 discharge
Medically necessary days:	40
Covered charges:	$65,000
Benefits available:	30 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	30

30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges.

OC 47:	1/26
OC A3:	1/30
Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier

EXAMPLE 3: LTR Days Exhaust Prior to Cost Outlier

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	30
Covered charges:	$55,000
Benefits available:	20 LTR
Covered days:	20
Noncovered days:	10

Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3	1/25
OSC 70:	1/21 -1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 4: Coinsurance Days Exhaust Prior to Cost Outlier and No LTR Days Are Available

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available:	20 coinsurance
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	1/25
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 5: Coinsurance Days Exhaust Prior to Cost Outlier. LTR Days Exhausts in the Cost Outlier

Date of Service:	1/1 - 2/10 discharge
Medically necessary days	40
Covered charges	$65,000
Benefits available:	20 coinsurance and 10 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	35

35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	2/4
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

EXAMPLE 6: Full and Coinsurance Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available:	10 full and 20 coinsurance
Covered days:	30

Noncovered days:	0
Cost report days:	30

All charges for Medicare approved revenue codes billed as covered.

OC 47:	Not needed
Reimbursement:	Full DRG payment plus cost outlier based on $55,000 covered charges.

EXAMPLE 7: Coinsurance Days and LTR Days Exhaust in the Cost Outlier

Date of Service:	1/1 - 2/28 discharge
Medically necessary days	58
Covered charges	$83,000
Benefits available:	10 full, 30 coinsurance and 10 LTR
Covered days:	50
Noncovered days:	8
Cost report days:	50

50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges

OC 47:	1/26
OC A3:	2/19
Reimbursement:	Full DRG payment, plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

EXAMPLE: 8: LTR Days Exhaust Prior to Cost Outlier and Noncovered Span(s) Present

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	28
OSC 76	1/10 - 1/11
Covered charges:	$55,000
Benefits available:	20 LTR
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/28
OC A3	1/27
OSC 70:	1/23 -1/27
Reimbursement:	Full DRG payment, no cost outlier

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare Advantage (MA) Enrollees

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

During the period January 1, 1998 through December 31, 1998, hospitals received 20 percent of the fee-for-service DGME and operating IME payment. This amount increased by 20 percentage points each consecutive year until it reached 100 percent in calendar year (CY)

2002.

Non-IPPS hospitals and units may submit their MA claims to their respective A/B MACs (A) to be processed as no-pay bills so that the MA inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.

This applies to the following hospitals and units excluded from the IPPS:

- Rehabilitation units
- Psychiatric units
- Rehabilitation hospitals
- Psychiatric hospitals
- Long-term Care hospitals
- Children's hospitals
- Cancer hospitals

In addition, this applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their MA enrollees under 42 CFR §413.87(e). These providers may similarly submit their MA claims to their respective A/B MACs (A) to be processed as no-pay bills so that the MA inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the MA N&AH payment through the cost report.

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular A/B MAC (A) with condition codes 04 and 69. The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill to the PS&R report type 118 for MA enrollees in non-IPPS hospitals and non-IPPS units to capture MA inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

The A/B MAC (A) submits the claim to the Common Working File (CWF). The CWF determines if the beneficiary is a MA enrollee and what his/her plan number and effective dates are. The plan must be a MA plan, per 42 CFR §422.4. Upon verification from CWF that the beneficiary is a MA enrollee, the A/B MAC (A) adds the MA plan number and an MA Pay Code of "0" to the claim. For fee-for-service claims that were previously paid and posted to history for the same period (due to late posting of MA enrollment data), an L-1002 Automatic Cancellation Adjustment Report will be sent to the A/B MAC (A) when a DGME-only or a N&AH-only claim from a non-IPPS hospital or unit is accepted for payment by CWF. No deductible or coinsurance is to be applied against this claim nor is the beneficiary's utilization updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a MA enrollee, CWF rejects the claim and the A/B MAC (A) notifies the hospital of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. No interim bills should be submitted for DGME-only or N&AH-only claims and no Medicare Summary Notices should be prepared for these

claims.

The DGME payments are made using the same interim payment calculation A/B MACs (A) currently employ. Specifically, A/B MACs (A) must calculate the additional DGME payments using the inpatient days attributable to MA enrollees. As with DGME and N&AH education payments made under fee-for-service, the sum of these interim payment amounts is subject to adjustment upon settlement of the cost report. Note that these DGME and/or N&AH payments apply both to IPPS and non-IPPS hospitals and units.

Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for MA enrollees. The MA inpatient days are recorded on PS&R report type 118. For services provided to MA enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their A/B MAC (A) for these cases in accordance with this section's instructions. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report MA inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

30 - Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)

(Rev. 68, 10-16-04)

A3-3610.19, HO-415.19, A3-3610.20, HO-415.20

The Medicare law allows establishment of a Medicare rural hospital flexibility program by any State that has submitted the necessary assurances and complies with the statutory requirements for designation of hospitals as critical access hospitals (CAHs).

To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, or must be located in a Metropolitan Statistical Area (MSA) of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or critical access hospital unless it is designated by the State, prior to January 1, 2006, to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a length of stay, as determined on an annual average basis, of no longer than 96 hours.

The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS.

A. - Grandfathering Existing Facilities

As of October 1, 1997, no new Essential Access Community Hospital (EACH) designations can be made. The EACHs designated by CMS before October 1, 1997, will continue to be paid as sole community hospitals for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. The CAH's length of stay will be calculated by their A/B MAC (A) based on patient census data and reported to the CMS regional office (RO). If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS RO, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

1. The facility has been certified as a CAH by CMS;

2. The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and

3. The facility has been granted swing-bed approval by CMS.

A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

1. The facility distinct part unit has been certified as a CAH by CMS;

2. The distinct part unit meets the conditions of participation requirements for hospitals;

3. The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;

4. Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit was established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities in CAHs are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, Section 140

for billing requirements) and the Inpatient Psychiatric Units in CAHs are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);

5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;

6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101 percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply:

- The lesser of costs or charges (LCC) rule;
- Ceilings on hospital operating costs;
- The reasonable compensation equivalent (RCE) limits for physician services to hospitals; and
- The payment window provisions for preadmission services treated as inpatient services under §40.3. (Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient, are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill (85x TOB) from inpatient services. CWF and the shared system shall bypass the CAH provider numbers when applying the edits that compare hospital outpatient and inpatient bills to apply the window provisions. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.)

Low Osmolar Contrast Material (LOCM) furnished as part of medically necessary imaging procedures for inpatients is paid for based on bill type 11X (for LOCM furnished during an inpatient stay covered under Part A), or 12X(for LOCM furnished to an inpatient where payment is under Part B because the stay is not covered under Part A). Bills must include revenue code 636 along with one of the following HCPCS codes as appropriate:

A4644 Supply of low osmolar contrast material (100 - 199 mgs of iodine);

A4645 Supply of low osmolar contrast material (200 - 299 mgs of iodine); or

A4646 Supply of low osmolar contrast material (300 - 399 mgs of iodine).

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirements. Inpatient services should be billed on an 11X type of bill.

30.1.1.1 - Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, Issued 07-23-04, Effective: 01-01-04, Implementation: 01-03-05)

Reimbursement to IHS or Tribal CAHs for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information.

Payment for inpatient IHS or Tribal CAH services is at 100% of the facility specific per diem rate less applicable deductible and coinsurance. Inpatient services should be billed on an 11X type of bill.

Beginning January 1, 2004, IHS or Tribal CAHs are paid 101% of the facility specific per diem rate.

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

The SNF-level services provided by a CAH, are paid at 101% of reasonable cost. Since this is consistent with the reasonable cost principles, A/B MACs (A) **will now** pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

Coinsurance and deductible are applicable for inpatient CAH payment.

All items on the ASC X12 837 institutional claim format are completed in accord with the implementation guide applicable to the dates of the stay. All items on Form CMS-1450 are completed in accordance with Chapter 25.

30.1.3 - Costs of Emergency Room On-Call Providers

(Rev. 803, Issued: 01-03-06, Effective: 04-03-06, Implementation: 04-03-06)

For dates of service on or after January 1, 2005, the reasonable costs of outpatient CAH services may include the reasonable compensation and related costs for an emergency room provider who is on call but not present at the premises of the CAH, if the provider is not otherwise furnishing provider services and is not on call at any other provider or facility. The costs are allowable only if they are incurred under a written contract that requires the provider to come to the CAH when the provider's presence is medically required. An emergency room provider must be a doctor of medicine or osteopathy, physician assistant, nurse practitioner, or clinical nurse specialist who is immediately available by telephone or radio contact, and available on site, on a 24-hour a day basis, within 30 minutes, or within 60 minutes in areas described in 42 CFR 1395(g)(5).

For dates of service from October 1, 2001, through December 31, 2004, this provision covers only emergency room physicians. An emergency room physician must be a doctor of medicine or osteopathy.

30.1.4 - Costs of Ambulance Services
(Rev. 1, 10-01-03)

Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or by an entity that is owned and operated by a CAH is, under certain circumstances, the reasonable cost of the CAH or the entity in furnishing those services. Payment is made on this basis only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity. Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply.

The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals
(Rev. 2388, Issued: 01-20-12, Effective: 04-22-12, Implementation: 04-22-12)

A. - General

Days of utilization are charged based upon actual days of coverage including grace and waiver days. The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. The hospital collects the coinsurance, if applicable, for only the number of days charged against the beneficiary's utilization record maintained by CMS. For example, if the mean length of stay for a DRG is 10 days and the beneficiary is discharged after 3, only 3 days of utilization is charged. In a like situation, if the DRG mean length of stay is 10 days and the beneficiary is discharged after 15, the 15 days are charged against the utilization record.

NOTE: There are some exceptions to this rule under LTCH PPS. See §150.4.

Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the DRG payment. Days after benefits are exhausted are not charged against the beneficiary's utilization even though the hospital may receive the full DRG payment.

The basic prospective payment amount will be paid if:

- There is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium).

- There is at least l day for which payment may be made under the guarantee of payment. (If benefits are exhausted prior to admission and no payment may be made under guarantee of payment, only Part B benefits are available.)

- The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Utilization is not counted for any days treated as noncovered, except as described below:

- Utilization is not counted for any nonentitlement days, or days after benefits are exhausted (including guarantee of payment days), even if those days are treated as covered for outlier calculation or treated as Medicare patient days for the cost report.

- The length of stay exceeds the day/cost outlier threshold (Day outliers were discontinued at the end of FY 1997), utilization is counted for medically unnecessary days which are noncovered but for which the hospital may not charge the beneficiary because the requirements of §40.2 were not met. See §40.2.2 for identification of these days.

- If the adjusted cost of the stay exceeds the cost outlier threshold, utilization is counted for any medically unnecessary days on which all Part A services are treated as noncovered under §40.2.B and for which the hospital may not charge the beneficiary. (Where only ancillary services are denied, all days are counted as covered.)

Lifetime reserve days (LTR) for an inpatient hospital stay for which prospective payment may be made is subject to the following:

If the beneficiary had one or more regular benefit days (full or coinsurance days) remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the nonoutlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. IPPS uses Occurrence Span code 70 for the covered non-utilization period after regular benefit days are exhausted or when only LTR days are exhausted. For example:

EXAMPLE 1: No Cost Outlier, only LTR Days available and Exhaust prior to discharge

Dates of Service	01/05 - 01/16
Medically necessary days	11
Benefit days available VC 83	1 LTR
Covered days VC 80	1
Noncovered days VC 81	10
Cost report days	11
OC A3	01/15(includes covered non-utilization period)
OSC 70	01/06 - 01/15
Room & Board revenue code	11 Total & Covered units
Medicare approved revenue codes	Charges in covered
Reimbursement	Full DRG payment, no cost outlier
Beneficiary Liability:	LTR copayment amount

EXAMPLE 2: No Cost Outlier, Coinsurance Days available and Exhaust prior to discharge

Dates of Service	01/05 - 01/16
Medically necessary days	11
Benefit days available VC 82	3 Coinsurance
Covered days VC 80	3
Noncovered days VC 81	8
Cost report days	11
OSC 70	01/08 - 01/15
Room & Board revenue code	11 Total & Covered units
Medicare approved revenue codes	Charges in covered
Reimbursement	Full DRG payment, no cost outlier
Beneficiary Liability	Coinsurance copayment amount

After regular benefits have been exhausted, lifetime reserve days will be used automatically for outlier days unless the beneficiary elects not to use them, or the average daily charges for outlier days to be reimbursed as lifetime reserve days do not exceed the lifetime reserve day coinsurance amount. (In the latter case the beneficiary is deemed to have elected not to use lifetime reserve days for outlier days.) An election not to use lifetime reserve for outlier days applies to all outlier days in an admission.

- If the beneficiary had no regular benefit days remaining when admitted, available lifetime reserve days are used automatically for each day of the stay. Exceptions exist if the beneficiary elects not to use lifetime reserve days, or the charges for which the beneficiary is liable, if electing not use lifetime reserve days, do not exceed the charges for which the beneficiary would be liable if the lifetime reserve days were used. Using lifetime reserve days, the beneficiary would be responsible for the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days are available. (In the latter case the beneficiary will be deemed to have elected not to use any lifetime reserve days.)

An election by the beneficiary not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay. A deemed election not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay unless payment may be made under the guarantee of payment.

The number of days for which utilization is charged may be different from the number used in Pricer to compute outlier status or the number of Medicare patient days shown on the cost report.

40.1 - "Day Count" Rules for All Providers
(Rev. 1, 10-01-03)

A3-3620

See §40.2.A for general rules on counting days.

A. - Day of Admission

For all hospitals, the A/B MAC (A) counts the day of admission for the cost report and for utilization. For PPS hospitals, it counts the day of admission for Pricer purposes unless the rules for same day transfer apply.

B. - Day of Discharge, Death, or Beginning a Leave of Absence

The A/B MAC (A) does not count the day of discharge or death for cost report, utilization or Pricer purposes unless the admission and discharge day are the same day. Where admission and discharge occur on the same day, it counts one day for cost report, utilization and Pricer purposes. If the patient is admitted with the expectation that the patient will remain overnight, but is discharged or dies before midnight, it counts the day for the cost report, utilization and Pricer. It does not count any days in a leave of absence (occurrence span code 74), for cost report, utilization or Pricer purposes.

C. - Same Day Transfer From Participating Hospital to Nonparticipating Hospital or Nonparticipating Distinct Part of Hospital

If the beneficiary is admitted to a PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight, the A/B MAC (A) counts the day for the cost report, utilization and Pricer. If the beneficiary is admitted to a non-PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating hospital or a nonparticipating distinct part of a hospital before midnight, the A/B MAC (A) counts the day for cost report and utilization purposes.

D. - Same Day Transfer From Participating Hospital to Participating Hospital

If the beneficiary is transferred to a participating hospital or distinct part of a participating hospital, the A/B MAC (A) counts the day, if it is determined to be covered, for the cost report and for Pricer at both hospitals. However, it charges utilization on the bill only for the later admission to avoid charging the beneficiary twice for the same day. The earlier admission, for which the A/B MAC (A) does not charge utilization, can be recognized by condition code 40 (same day transfer), and the same date entered in the "From" and "Through" dates in CWF.

E. - Guarantee of Payment Days

There can be up to fourteen guarantee of payment days (8 days plus weekends and Federal holidays) beginning with the date in occurrence code 20. The A/B MAC (A) does not charge utilization, as the beneficiary has no days remaining, but counts guarantee of payment days for the cost report and Pricer.

F. - Provider Liability Issue

When the A/B MAC (A) or the QIO finds the provider liable, the A/B MAC (A) or the QIO determines the cause for provider liability prior to making any decision regarding utilization. If the provider is technically liable, i.e., liable for reasons other than custodial care or medical necessity of the services, the A/B MAC (A) shows the dates of provider liability in occurrence span code 77, and counts the days for utilization, but not for cost report or Pricer purposes. If the provider is liable because services were not medically necessary or were

custodial care, the A/B MAC (A) shows the dates of provider liability in occurrence span code 79 and does not count the days for cost report, utilization or Pricer purposes.

G. - Special Rules Which Differ for PPS and Other Providers

If Part A payment may be made for a hospital stay under PPS (i.e., there is at least one Medicare patient day, guarantee of payment day, or day for which the program is liable to the hospital under the limitation of liability provision), the A/B MAC (A) treats all days as covered for cost report purposes, except as provided below. It applies this same rule when per diem payments are made to a transferring PPS hospital, whether for all or part of a stay, or when a PPS hospital requests outlier payment, whether or not such payment is made.

For non-PPS hospitals, PPS exempt units and SNFs, it counts the number of days available to the beneficiary for all purposes.

Where outlier status is involved and there are either pre-entitlement days or days after benefits were exhausted, the A/B MAC (A) reduces cost report days by the lesser of the number of pre-entitlement/post-benefits exhausted days or the number of days in the stay in excess of the outlier threshold.

1. Length of Stay Does Not Exceed the Day Outlier Threshold (Day outliers discontinued after FY 97)

The A/B MAC (A) counts all days (including day of admission, but not the day of discharge or death, unless it is also the day of admission) as covered for cost report and Pricer purposes. It does not count those medically unnecessary days for which the provider meets notice requirements and other conditions for charging the beneficiary. (See §40.2.2 C and D.) It does not count those medically unnecessary days for cost report or Pricer purposes. It counts the actual number of days available to the beneficiary for utilization.

2. Length of Stay Exceeds the Day Outlier Threshold (Day outliers discontinued after FY 97)

The A/B MAC (A) counts all days (including the day of admission, but not the day of discharge or death unless it is also the day of admission) in the stay for cost report and Pricer purposes except as follows:

a. Pre-entitlement Days

The A/B MAC (A) does not count pre-entitlement days for the cost report or for utilization in non-PPS hospitals, exempt units or SNFs. For PPS hospitals, it does not count pre-entitlement days for utilization or for Pricer. The number of days counted as noncovered for the cost report is limited to the number of days in the stay in excess of the day outlier threshold. To determine which preentitlement days are counted as noncovered, the A/B MAC (A) begins at the end of the stay (the day before the day of discharge, death, etc.) and working backward, counts off days identified as pre-entitlement days until it has counted all preentitlement days or, until the number of days counted equals the total number of days in excess of the outlier threshold.

b. Post-Exhaustion of Benefit Days

The A/B MAC (A) treats post-exhaustion of benefit days exactly like pre-entitlement days.

To resolve any Medicare Secondary Payor (MSP) issues, see the Medicare Secondary Payer Manual.

40.2 - Determining Covered/Noncovered Days and Charges

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

The CMS must record a day or charge as either covered or noncovered because of the following:

Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care. Days denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable.

The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made, i.e., provider liable days and charges are not included. Data from the bill payment process are used in preparing the cost report.

The number of days and charges provided to the Pricer program affects the day and cost outlier determinations and the DRG payment amount. Non-PPS provider days are excluded from Pricer consideration.

It is possible to use a different number of days on a single bill for each of the above purposes, although the same number of days will generally apply in actual practice. For example, if the beneficiary had at least 1 day of eligibility remaining at admission, days that occur after benefits are exhausted up through the day outlier threshold for the applicable DRG are counted for cost reporting purposes under IPPS (see section190.12.1 for IPF and section 150.17 for LTCH benefits exhaust claims processing).

A. - General Rule on Counting of Days

These following are general rules for counting days. However, these rules are also subject to special rules for determining day of admission, discharge, death, beginning a leave of absence, same day transfer, guarantee of payment days, provider liability issues and outlier days for PPS outliers. See §40.1 and §40.1.G for an explanation of these special rules.

The provider calculates and enters on the bill the number of claimable Medicare patient days on the cost report. (Medicare patient days always refer to cost report days.) For PPS facilities the A/B MAC (A) counts, for the cost report, utilization and Pricer purposes, all days for which Part A payment may be made to the hospital. This includes days for which the provider is not liable under the limitation of liability provision. It does not count days for which no Part A payment may be made for cost report, utilization or Pricer purposes.

For non-PPS providers, the A/B MAC (A) does not count the days for Pricer purposes, because DRG payment or outlier calculations are not made.

B. - Medically Unnecessary Days for Which the Provider May Charge the Beneficiary

Days on which the hospital furnished no covered Part A services are not charged to utilization and are not counted as Medicare patient days.

If the hospital or SNF stay includes any medically unnecessary days for which the provider has met the requirements of §§40.2.2 C or D for charging the beneficiary, the A/B MAC (A) counts those days as noncovered under Part A for cost report, utilization and Pricer purposes.

Since the provider may not be aware of the date benefits are exhausted or when the outlier threshold is reached, the A/B MAC (A) verifies the provider's counts. If, for any reason, the A/B MAC (A) or the QIO determines fewer days are claimable (e.g., if the A/B MAC (A) or the QIO indicates that benefits are exhausted), the A/B MAC (A) will adjust cost report days for its PS&R system. If the A/B MAC (A) or the QIO determines fewer days are claimable for the cost report, it determines the proper number of days of utilization to charge the beneficiary and the proper number of days for the length of stay used by Pricer. It uses the factors in §40.1 and §40.1G to make these calculations.

C. - Medically Unnecessary Outlier Costs for Which the Hospital May Not Charge

If the hospital requests payment for cost outlier, and the Medicare covered charges converted to cost exceed the cost outlier threshold, the services which are not reasonable and necessary (or constitute custodial care) which are noncovered, but for which the hospital may not charge the beneficiary are determined as follows:

- The hospital determines the lesser of the following:
    - The cost of the medically unnecessary services (converting the charges for the medically unnecessary services to cost); or
    - The amount by which the adjusted cost of the stay exceeds the cost outlier threshold.

Ancillary services, which are not required to be furnished on an inpatient basis, are treated as medically unnecessary, but nevertheless may be covered under Part B.

- If the costs in excess of the outlier threshold exceed the cost of the medically unnecessary services, the cost of all of the medically unnecessary services are treated as noncovered costs. If these costs exceed the costs in excess of the cost outlier threshold, beginning with the cost of the last medically unnecessary service in the stay, the hospital must identify, and add on, in reverse order, the cost of other medically unnecessary services until the total cost of medically unnecessary services reaches the costs in excess of the cost outlier threshold. If the cost of the last service to be added on in this manner brings the cost of medically unnecessary services over the amount of costs in excess of the cost outlier threshold, only the portion of the cost of that last medically unnecessary service (in the order of the addition) needed to bring the total of the medically unnecessary costs up to the costs in excess of the cost outlier threshold is added on. In this case, the costs in excess of the cost outlier threshold are treated as the noncovered costs.

- Once the costs of medically unnecessary services to be treated as noncovered are determined, convert them to charges for each applicable service/revenue category, e.g., accommodations, radiology, pharmacy, by dividing the costs treated as not

medically necessary in each category by 72 percent. The medically unnecessary charges determined are treated as noncovered charges. Days for which all costs are found to be noncovered are treated as noncovered days.

- The hospital determines which medically unnecessary services and days treated as noncovered are services and days for which the beneficiary can be charged under §40.2.2C or E. The remainder of the services and days are the medically unnecessary services and days treated as noncovered even though the hospital may not charge the beneficiary. However, the distinction between medically unnecessary services and days for which the hospital may charge, and those for which it may not, will not be reflected in the charges shown on the inpatient hospital billing. Both are combined and shown as noncovered services and days.

The determination of medically unnecessary cost outliers is not affected by non-entitlement days or days after benefits are exhausted. If the stay is covered or treated as covered, the beneficiary is treated as entitled to Part A, and as having benefits available throughout the stay.

40.2.1 - Noncovered Admission Followed by Covered Level of Care

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Where a beneficiary receives noncovered care at admission, and is notified as such, but subsequently is furnished covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. This is applicable to PPS and non-PPS billings.

The following billing entries identify this situation:

- Admission date (not the deemed date).
- Occurrence code "31" and the date the hospital provided notice to the beneficiary.
- Occurrence span code 76 indicates the noncovered span from admission date through the day before covered care started.
- Value code 31 is used to indicate the amount which was charged the beneficiary for noncovered services.
- Noncovered charges related to the noncovered services.
- The principal diagnosis is shown as the diagnosis that caused the covered level of care.
- Only procedures performed during the covered level of care are shown on the bill.

If a no payment bill for the noncovered level of care has been processed, the hospital prepares and forwards a new initial bill.

40.2.2 - Charges to Beneficiaries for Part A Services

(Rev. 1495; Issued: 05-02-08; Effective Date: 10-01-08; Implementation Date: 10-06-08)

The hospital submits a bill even where the patient is responsible for a deductible which covers the entire amount of the charges for non-PPS hospitals, or in PPS hospitals, where the DRG payment amount will be less than the deductible.

A hospital receiving payment for a covered hospital stay (or PPS hospital that includes at least one covered day, or one treated as covered under guarantee of payment or limitation on liability) may charge the beneficiary, or other person, for items and services furnished during the stay only as described in subsections A through H. If limitation of liability applies, a beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 of this manual. For related notices for inpatient hospitals, see CMS Transmittal 594, Change Request3903, dated June 24, 2005.

A. - Deductible and Coinsurance

The hospital may charge the beneficiary or other person for applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. The A/B MAC (A) deducts the deductible and coinsurance first from the PPS payment. Where the deductible exceeds the PPS amount, the excess will be applied to a subsequent payment to the hospital. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

B. - Blood Deductible

The Part A blood deductible provision applies to whole blood and red blood cells, and reporting of the number of pints is applicable to both PPS and non-PPS hospitals. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.) Hospitals shall report charges for red blood cells using revenue code 381, and charges for whole blood using revenue code 382.

C. - Inpatient Care No Longer Required

The hospital may charge for services that are not reasonable and necessary or that constitute custodial care. Notification may be required under limitation of liability. See CMS Transmittal 594, Change Request3903, dated June 24, 2005, section V. of the attachment, for specific notification requirements. Note this transmittal will be placed in Chapter 30 of this manual at a future point. Chapter 1, section 150 of this manual also contains related billing information in addition to that provided below.

In general, after proper notification has occurred, and assuming an expedited decision is received from a Quality Improvement Organization (QIO), the following entries are required on the bill the hospital prepares:

- Occurrence code 3l (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;

- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and

- Value code 3l (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D. - Change in the Beneficiary's Condition

If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the QIO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after the beneficiary again required inpatient hospital care until proper notification occurs (see subsection C).

If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with another notice when the patient chose not to be discharged to the SNF bed.

E. - Admission Denied

If the entire hospital admission is determined to be not reasonable or necessary, limitation of liability may apply. See 2005 CMS transmittal 594, section V. of the attachment, for specific notification requirements.

NOTE: This transmittal will be placed in Chapter 30 of this manual at a future point.

In such cases the following entries are required on the bill:

- Occurrence code 3l (and date) to indicate the date the hospital notified the beneficiary.

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.

- Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.

- Value code 3l (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization that was not necessary or reasonable. They are included as noncovered charges on the bill.

F. - Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary

If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires

inpatient hospital care) the hospital may charge the beneficiary or other person for the services or care according the procedures given in CMS Transmittal 594, Change Request3903, dated June 24, 2005.

The following bill entries apply to these circumstances:

- Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.

- Value code 3l (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G. - Nonentitlement Days and Days after Benefits Exhausted

If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). It may charge the beneficiary for the lesser of:

- The number of days on which the patient was not entitled to benefits or after the benefits were exhausted; or

- The number of outlier days. (Day outliers were discontinued at the end of FY 1997.)

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits, or after benefits were exhausted, the hospital may charge for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until the number of days counted off equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H. - Contractual Exclusions

In addition to receiving the basic prospective payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, non-entitlement to Part A, or exhaustion of benefits. For example, it may charge for most cosmetic and dental surgery.

I. - Private Room Care

Payment for medically necessary private room care is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See the Medicare Benefit Policy Manual, Chapter 1.) When the beneficiary accepts the liability, the hospital will supply the service, and bill the beneficiary directly. If the beneficiary believes the private room was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

J. - Deluxe Item or Service

Where a beneficiary requests a deluxe item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition, the hospital may collect the additional charge if it informs the beneficiary of the additional charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested. If the beneficiary believes that the more expensive item or service was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

K - Inpatient Acute Care Hospital Admission Followed By a Death or Discharge Prior To Room Assignment

A patient of an acute care hospital is considered an inpatient upon issuance of written doctor's orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of their own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07 which indicates they left against medical advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

40.2.3 - Determining Covered and Noncovered Charges - Pricer and PS&R
(Rev. 1, 10-01-03)

Accommodation charges for days covered by Medicare are covered charges. Ancillary charges incurred on these days are also covered charges as long as these services are covered under Medicare. The A/B MAC (A) enters them into its PS&R unless it or the QIO denies them as exclusions from coverage or as medically unnecessary. For PPS hospitals, the A/B MAC (A) counts these charges for Pricer unless the charges are included as pass-through costs.

The A/B MAC (A) does not count for Pricer or the PS&R:

- Charges the provider has shown as noncovered. (If the provider has complied with the notice requirements in Chapter 30, it may bill the beneficiary.);
- Services on noncovered days;
- Charges for personal comfort and/or convenience items;
- Accommodations and routine charges for the day of discharge, death, or beginning of a leave of absence, unless it is also the day of admission; and
- Charges for ancillary services on the day of discharge, death, or beginning of a leave of absence if the preceding day is noncovered under §40.2.B.

MSP Issues

The A/B MAC (A) resolves any MSP issues not handled by §40.1.G using the instructions in the Medicare Secondary Payer Manual specific for reasonable cost providers and the instructions in specifically for PPS providers.

Determining Covered and Noncovered Charges - Part B

The A/B MAC (A) counts as covered under Part B, for cost report and deductible purposes, the charges for which Part B payment may be made, except as follows:

- It counts as covered for deductible, but not cost report purposes, those charges for which the provider is liable for technical reasons; and

- It does not count charges for which the provider is liable because services are not medically necessary for either deductible or cost report purposes.

40.2.4 - IPPS Transfers Between Hospitals

(Rev. 3431, Issued: 12-29-15, Effective: 10-01-15, Implementation: 10-05-15)

A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See §20.2.3 for proper Pricer coding to ensure that these requirements are met.

Note: CMS established Common Working File Edits (CWF) edits in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

A. - Transfers Between IPPS Prospective Payment Acute Care Hospitals

For discharges occurring on or after October 1, 1983, when a hospital inpatient is discharged to another acute care hospital, as described in 42 CFR 412.4(b), payment to the transferring hospital is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount). If the stay is less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital (see §40.1.D). If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate. Payment is made to the final discharging hospital at the full prospective payment rate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage index values and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each is based upon the MS-DRG under which the patient was treated. For transfers on or after October 1, 1984, the transferring hospital may be paid an outlier payment. For further information on outlier payments for transfer cases, see section 20.1.2.4 of this manual.

An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

Effective for discharges on or after October 1, 2003, patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

B. - Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units Excluded from the IPPS

When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or is made at the rate of its respective payment system (see exceptions in paragraph C of this section).

A transfer payment is made to the transferring hospital when patients are transferred to a hospital that would ordinarily be paid under prospective payment, but that is excluded because of participation in a state or area wide cost control program. Also, a transfer payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS and certain hospitals that are excluded from IPPS. These include:

- An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Status Code 02)

- A critical access hospital (Patient Status Code 66)

C. - Postacute Care Transfers
(Previously Special 10 DRG Rule)

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Postacute MS-DRGs referenced in paragraph (D) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CRF 412). Facilities excluded from IPPS are inpatient rehabilitation facilities and units (Patient Status Code 62), long term care hospitals (Patient Status Code 63), psychiatric hospitals and units (Patient Status Code 65), children’s hospitals, and cancer hospitals (Patient Status Code 05).

- To a skilled nursing facility (Patient Status Code 03).

- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Status Code 06).

Specific transfer cases under this paragraph qualify for payment under an alternative methodology. These include transfer cases in which the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in paragraph (D) of this section. For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

D. - Qualifying MS-DRGs

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.

40.2.5 - Repeat Admissions

(Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers must not use the leave of absence billing procedure when the second admission is unexpected.

The A/B MACs (A) may choose to review claims if data analysis deems it a priority. AB/MACs (A) will review the claim selected, based on the medical record associated with that claim and make a payment determination on that claim. They will then refer the claim to the QIO, in accordance with IOM 100-08, chapter 6, §6.5.7.

The QIOs may review acute care hospital admissions occurring within 30 days of discharge from an acute care hospital if both hospitals are in the QIO's jurisdiction and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.

NOTE: The QIO's authority to review and to deny readmissions when appropriate is **not** limited to readmissions within 30 days. The QIO has the authority to deny the second admission to the same or another acute PPS hospital, no matter how many days elapsed since the patient's discharge.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one DRG payment is made. The A/B MACs (A) do not consider leave of absence bills as two admissions. It may select such bills for review for other reasons.

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for

symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Services rendered by other entities during a combined stay must be paid by the acute care PPS hospital. The acute care PPS hospital is responsible for the other entity's services per common Medicare practice.

NOTE: Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital.

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Upon the request of A/B MACs (A), hospitals must submit medical records pertaining to the readmission.

For Non-PPS acute care hospitals, such as Maryland waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month. However, the original bill would have to be adjusted to change the patient status code to a 30 (still a patient). Subsequent monthly bills for this admission would be billed as interim bills, 112, 113 or 114.

40.2.6 - Leave of Absence

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Providers submit one bill for covered days and days of leave when the patient is ultimately discharged.

The provider bills for covered days with days of leave included in Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by their A/B MAC (A) on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

Where a patient on leave of absence from a non-PPS hospital who was shown as "Still Patient" (patient status code 30) on an interim bill:

- Has not returned within 60 days, including the day leave began, or
- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

A. - Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and A/B MACs (A) apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for A/B MAC (A) requirements for detecting duplicate claims in such cases.

B. - Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS

are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, outpatient diagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

Code	**Description**
0254	Drugs incident to other diagnostic services

Code	Description
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X	CT scan
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services
040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
053X	Osteopathic services
061X	MRT
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG
074X	EEG
0918-	Testing- Behavioral Health
092X	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services

when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C. - Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991 and Before June 25, 2010)

Nondiagnostic outpatient services that are related to a beneficiary's hospital admission and that are provided by the admitting hospital, or by an entity that is wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The A/B MAC (A) shall assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B. This provision applies only when the beneficiary has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Hospitals must not include on a claim for an inpatient admission any outpatient nondiagnostic services that are not payable under Part B. For example, oral medications that are considered self-administered drugs under Part B are not payable under the outpatient prospective payment system (OPPS) and must not be bundled on an inpatient claim for purposes of the 3-day (or 1-day) payment window policy.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore, outpatient nondiagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, admission-related outpatient nondiagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any admission-related outpatient nondiagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient nondiagnostic services that are included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient nondiagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient nondiagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, admission-related outpatient nondiagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008 and before June 25, 2010, CWF will reject claims for nondiagnostic services when the following is met:

> 1) There is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay, and
>
> 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

D. - Other Preadmission Services (Effective for Services Furnished <u>On or After</u> June 25, 2010)

Beginning on or after June 25, 2010, the definition of "other services related to the admission" (i.e., admission-related outpatient "nondiagnostic" services) is revised for purposes of the 3-day (or 1-day) payment window policy. Except for the following changes, the other requirements in section 40.3.C continue to be applicable.

For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

Hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient diagnostic services and all preadmission outpatient nondiagnostic services that meet the above requirements. For purposes of the Present on Admission Indicator (POA), even if the outpatient services are bundled with the inpatient claim, hospitals shall code any conditions the patient has at the time of the order to admit as an inpatient as POA irrespective of whether or not the patient had the condition at the time of being registered as a hospital outpatient. In combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD procedure codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window.

Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission and are covered by Part B may be separately billed to Part B. Hospitals must maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission.

Effective for dates of service on or after June 25, 2010, CWF will reject outpatient claims for nondiagnostic services when the following occurs:

> 1) Condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") is not included on the outpatient claim, and
>
> 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

40.3.1 - Billing Procedures to Avoid Duplicate Payments

(Rev. 1, 10-01-03)

HO-400H

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the DRG for a related inpatient admission in the facility or in another hospital.

Where the hospital bills separately for nonphysician services provided to a patient either on the day before admission to a PPS hospital or during a patient's inpatient stay, the claim will be rejected by the A/B MAC (A) as a duplicate and the hospital may be subject to sanction penalties per §1128A of the Act.

50 - Adjustment Bills

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of A/B MAC (A)'s medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be initiated as a result of OIG and MSP requests. The A/B MAC (A) will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill for Payer A, B, or C.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the A/B MAC (A) pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the A/B MAC (A) enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

NOTE: Information regarding the claim form locators that correspond with these fields on the Form CMS-1450 is found in chapter 25.

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the A/B MAC (A) initiates), the A/B MAC (A) submits an adjustment bill to CWF following its acceptance of the initial bill. To verify CMS' acceptance, it takes one or both of the following actions:

A. - General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- A/B MAC (A) control number (ICN/DCN);
- Surname;
- HICN;

When a definite match cannot be made on the 3 fields above, the provider's A/B MAC (A) will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and
- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect HICNs. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its A/B MAC (A) either electronically or on hard copy. Electronic submission is preferred.

The A/B MAC (A) must enter the following bill types that relate to the entity generating the adjustment request:

Bill Type	Description
XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	A/B MAC (A)
XXM	MSP

Bill Type	Description
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the A/B MAC (A) will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the A/B MAC (A) receives a CWF alert or a CMS-L1002.

The A/B MAC (A) prepares an adjustment if instructed by CO or RO to make a change. Typically, the A/B MAC (A) receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the A/B MAC (A) to correct it.

If the A/B MAC (A) furnished the A/B MAC (B) a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the A/B MAC (A) must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the A/B MAC (A) stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the A/B MAC (A) notes this and processes adjustments to subsequent bills if it services the provider.

If the A/B MAC (A) does not service the provider, CMS will contact the A/B MACs (A), which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an A/B MAC (A) of the appropriate adjustment actions.)

B. - Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the A/B MAC (A) payment notice for adjustment bills where diagnostic or procedure coding was in error.

Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the A/B MAC (A) without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The A/B MAC (A) processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date through the discharge date. When the adjustment bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, the A/B MAC (A) makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

50.1 - Tolerance Guidelines for Submitting Adjustment Requests

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

When a bill is submitted and the hospital or the A/B MAC (A) discovers an error, the hospital submits an adjustment request using the ASC X12 837 institutional claim format or the Form CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/non-covered days;
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing provider;
- Discharge status in a PPS hospital;
- Diagnosis or Procedures that impact the assigned DRG code; or
- Outlier payment amount.

The provider submits most adjustment requests as debits, using bill type XX7.

Also, it submits a debit-only adjustment request to the A/B MAC (A) if the hospital previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The A/B MAC (A) then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to CMS, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

50.2 - Claim Change Reasons

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

A. - Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its A/B MAC (A) with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a HICN or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the

claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the ASC X12 837 institutional claim format or on the hard copy Form CMS-1450 For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B. - Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The A/B MAC (A) must apply them to each incoming adjustment request.

- If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the A/B MAC (A) rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."

- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the A/B MAC (A) rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."

- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the A/B MAC (A) rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the A/B MAC (A) rejects the request back to the provider with the following message, "only one claim change reason code may apply to a single adjustment request from a provider. Choose the single claim change reason code that best describes the reason for the provider's request and resubmit."

- If the provider submits an adjustment request as type of bill not equal to XX7 or XX8, the A/B MAC (A) rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to XX7 or XX8."

- If the claim change reason code is equal to D0, the A/B MAC (A) compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."

- If the claim change reason code is equal to D1, the A/B MAC (A) compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the A/B MAC (A) rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."

- If the claim change reason code is equal to D2, the A/B MAC (A) compares revenue codes/HCPCS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS must change for claim change reason code D2."

- If the claim change reason code is equal to D3, the A/B MAC (A) compares the ending date on the provider's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Thru dates must change for the claim change reason code D3."

- If the claim change reason code is equal to D4, the A/B MAC (A) compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."

- If the claim change reason code is equal to D5 or D6, type of bill must be equal to XX8 on the provider's request. If type of bill is not equal to XX8, the A/B MAC (A) rejects the request back to the provider with the message, "Type of bill must be equal to XX8 for claim change reason codes D5 or D6."

- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the A/B MAC (A) rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."

- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the A/B MAC (A) rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the A/B MAC (A) rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."

- If the claim change reason code is equal to E0, the A/B MAC (A) compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the A/B MAC (A) rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

If an adjustment the provider initiates results in a change to a higher weighted DRG, the A/B MAC (A) edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the A/B MAC (A) processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the A/B MAC (A) processes the claim for payment and forwards it to CWF.

The A/B MAC (A) must suspend for investigation all adjustment requests with claim change reason codes D4, D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

C. - Additional edits

The A/B MAC (A) must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;
- A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;
- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for a PPS provider. The A/B MAC (A) must investigate if the change is from patient status 02, transferred to another acute care facility.

50.3 - Late Charges
(Rev. 1, 10-01-03)

HO-411.3, HO-IM411.3

Providers billing under Inpatient Hospital PPS, Outpatient PPS, SNF PPS, or HHA PPS may not bill late charges, nor will the contractor accept such bills, for any type of PPS service, inpatient or outpatient. Charges omitted from the original bill must be submitted on an adjustment bill that contains all pertinent charges including those billed earlier. When the provider submits late charges on bills to the A/B MAC (A) as bill type XX5, these bills contain **only** additional charges. Adjustment requests and not late charge bills should be submitted for

- Services on the same day as outpatient surgery subject to the ASC limit,
- ESRD services paid under the composite rate,
- All inpatient accommodation charges, and
- All inpatient PPS ancillaries as adjustment requests.

The provider may submit the following charges omitted from the original paid bill to the A/B MAC (A) as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for HHA services under either Part A or Part B, hospice services, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CHMC services, and ESRD services not included in the composite rate; and

- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS hospitals. The hospital may **not** submit late charges (XX5) for inpatient accommodations. The hospital must submit these as adjustments (bill type XX7).

The A/B MAC (A) has the capability to accept XX5 bill types electronically and process them as initial bills except as described in the following paragraph.

The A/B MAC (A) also performs the following edit routines on any XX5 type bills received:

- Pass all initial bill edits, including duplicate checks.

- Must not be for any of: Inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an XX7 debit-only or XX8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate."

- When an XX5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, HICNs equal, and patient surname equal), the A/B MAC (A) must determine the status of the original paid bill. If it is denied, the A/B MAC (A) must deny the late charge bill.

- If an xx5 does not suspend as a potential duplicate, the A/B MAC (A) rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (XX1)."

- If the original bill was approved and paid, the A/B MAC (A) compares the revenue codes on the original paid bill with the associated late charge bill:

    - For all providers (any bill type), if any are the same, and are revenue codes 041x, 042x, 043x, 044x, 063x, 076x, or 091x, the A/B MAC (A) or (HHH) rejects the bill back to the provider with the message, "You must submit an adjustment (7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

    - For HHAs (bill type 32X, 33X, or 34X), the A/B MAC (HHH) must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0291, 0293, 055x, 056x, 057x, 058x, 059x, 060x, 066x,

the A/B MAC (HHH) rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For hospital outpatient services (bill type 13X only), the A/B MAC (A) must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0255, 032x, 033x, 034x, 035x, 040x, 062x, 073x, 074x, 092x, or 0943, the A/B MAC (A) rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For RDFs (bill type 72X or 73X), the A/B MAC (A) must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 0634, 0635, 082x, 083x, 084x, 085x, or 088x, the A/B MAC (A) rejects the bill back to the provider with the message, “You must submit an adjustment (XX7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill.”

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the A/B MAC (A) must suspend and investigate the late charge bill.

- The A/B MAC (A) must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any XX5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The A/B MAC (A) may decide to perform additional edits on late charge bills.

60 - Swing-Bed Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Swing-bed services must be billed separately from inpatient hospital services. Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI. NOTE: The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.):

"U" = short-term/acute care hospital swing-bed;
"W" = long-term hospital swing-bed;
"Y" = rehabilitation hospital swing-bed; and
”Z”=CAH swing-bed.

Note that CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)). Certified registered nurse anesthetist services paid on a pass-through basis are also to be included on the CAH swing-bed bill.

A. - Inpatient Hospital Services in a Swing-Bed

The patient status code of 03 is inserted on the claim when the beneficiary swings from acute to SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The A/B MAC (A) indicates in the Statement Covers Through Date the last day of care at the hospital level.

If the beneficiary is discharged from a Medicare swing-bed and remains in the hospital, there is no need for a no-pay bill. However, if a beneficiary continues to receive care after completing their stay in a SNF swing-bed, in a NF swing-bed, the hospital must submit covered claims to Medicare.

B. - SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;

- State level agreements may call for varying types of bill coding Type of Bill. The CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the A/B MAC (A) accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, i.e., 18X or 21X. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown.

70 - All-Inclusive Rate Providers

(Rev. 1, 10-01-03)
A3-3660.4

70.1 - Providers Using All-Inclusive Rates for Inpatient Part A Charges

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Some providers have been approved to bill a flat fee charge for inpatient services based on either a daily basis or total stay basis for services furnished. This is an "All-Inclusive Rate." These charges may cover room and board, including ancillary services, or room and board only. These instructions explain the essential data entries that must be made using the ASC X12 837 institutional claim format or on the Form CMS-1450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate;

- One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate;

- One all-inclusive charge rate for accommodations and another for ancillary services, including the cost of blood in the all-inclusive rate; or

- One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing of the billing format or form.

A. - Accommodations

Revenue Codes - Codes that identify the accommodations furnished, ancillary services provided or billing calculation are entered in this field. The code indicates whether the rate includes charges for ancillary services or only room and board.

If the patient was furnished more than one type of accommodation, the loops or lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.

Where the all-inclusive rate varies with the type of accommodation, the Remarks field is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantitative measure for services furnished, by revenue category, to or for the patient which includes items such as the number of accommodation days, pints of blood, or renal dialysis treatments, is entered.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is entered.

Noncovered Charges - The total non-covered charges pertaining to the related revenue code for the current billing period is entered.

B. - Ancillary Services

One All-Inclusive Charge Rate - Hospitals with one all-inclusive charge rate, including ancillary services, are reflected in the revenue code. The total charge reflects the charge for both accommodations and ancillary services.

Separate Ancillary All-Inclusive Rate - Some providers segregate charges for ancillary services for billing purposes. Where a separate flat rate charge for ancillary services is incurred either on a daily or total stay basis, the provider enters separate codes for the services. These codes indicate whether the total charge includes only ancillary cost or includes other costs (i.e., blood).

If applicable, the following additional billing instructions are applied:

- Blood

  Whenever whole blood is furnished the patient, value codes and amounts are completed. If the all-inclusive rate does not include the charge for whole blood or packed cells, revenue codes, rates, service dates, units, and total charges are

completed in the same way a provider not using all-inclusive rates would complete them. When the provider discounts its customary charges for unreplaced blood to which the deductible is applicable, it shows the charges before the discount.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint is entered in value codes and amounts. No amount can be shown in the Total Charges column since the rate includes the cost of blood. It is not necessary to show the cost for any replaced blood.

- All-Inclusive Charges According to Disease, Injury, or Type of Treatment

  Providers that have a charge system based on the patient's illness or injury or type of treatment complete the applicable loops or line(s) for type of accommodation furnished showing number of days, rate, and total charges. The rate amount and total amounts must be the same. Blood entries are indicated as above.

- Physician's Component

  As with providers having a schedule of charges for individual services, the amount of any physician's component included in the all-inclusive charge is removed from the total covered charges before applying the inpatient deductible or coinsurance.

- Combined Billing

  CMS does not encourage the all-inclusive rate provider to combine bill. However, if it does, it must develop the capability and indicate in the Remarks field, the number and type of each service it is combined billing. To identify such cases, the remark "Combined Billing" must be written in the Remarks field.
  NOTE: Combined billing was eliminated with Outpatient PPS.

80 - Hospitals That Do Not Charge
(Rev. 1, 10-01-03)

A3-3660.5

Participating hospitals that do not charge individuals and also meet the exceptions to the law that normally exclude payment for expenses paid for directly or indirectly by a governmental entity, may be reimbursed the reasonable cost of furnishing covered services to Medicare beneficiaries. The following special procedures apply to their bills.

- Part A Services

Computing Medicare Billing Rate

The Medicare billing rate per day is determined by the following equation:

Total allowable inpatient cost = cost per day per patient

Total inpatient days

Thus, the billing rate that appears is the average inpatient cost per day per inpatient as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the A/B MAC (A) determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

Computing Medicare Billing Rate (Inpatient)

The Medicare billing rate is determined in the following manner:

Total available inpatient cost = Cost per day per patient

Total inpatient days

The A/B MAC (A) multiplies the cost per day per patient by 93 percent for short-term hospitals and by 98 percent for long-term hospitals. (See §2208.lE of the Provider Reimbursement Manual, Part I, for definitions of "short-term" and "long-term" hospitals.) Then it applies the following fixed percentages. The result is the Medicare billing rate.

Computing Medicare Billing Rate (Outpatient)

The Medicare billing rate is determined by the following equation:

Total allowable outpatient cost = average cost per visit

Total visits (occasions of service)

Thus, the billing rate is the average cost per outpatient visit as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the A/B MAC (A) determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

80.1 - Medicare Summary Notice (MSN) for Services in Hospitals That Do Not Charge

(Rev. 1, 10-01-03)

A3-3660.5.A

Where the hospital does not charge for outpatient services, the A/B MAC (A) does not send the individual an MSN. This avoids confusion and the appearance that the beneficiary is liable for services received.

90 - Billing Transplant Services

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Medicare covers the following organ transplants: kidney, heart, lung, heart/lung, liver, pancreas, pancreas/kidney, and intestinal/multi-visceral. Medicare also covers stem cell transplants for certain conditions.

On March 30, 2007, the Department of Health and Human Services (DHHS) established a regulation authorizing the survey and certification of organ transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the Federal agency responsible for monitoring compliance with the Medicare conditions of participation. All hospital transplant programs covered by the regulation (does not include stem cell transplants), whether currently approved by CMS or seeking initial approval, must submit a request for approval under the new regulations to CMS by December 26, 2007 (180 days from the effective date of the regulation.)

http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

Transplant hospitals should review the above Web site and send applications to the following address:

Centers for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

The A/B MACs (A) may choose to review claims if data analysis deems it a priority.

90.1 - Kidney Transplant - General

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A3-3612, HO-E414

A major treatment for patients with ESRD is kidney transplantation. This involves removing a kidney, usually from a living relative of the patient or from an unrelated person who has died, and surgically placing the kidney into the patient. After the beneficiary receives a kidney transplant, Medicare pays the transplant hospital for the transplant and appropriate standard acquisition charges. Special provisions apply to payment. For the list of approved Medicare certified transplant facilities, refer to the following Web site:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

A transplant hospital may acquire cadaver kidneys by:

- Excising kidneys from cadavers in its own hospital; and
- Arrangements with a freestanding organ procurement organization (OPO) that provides cadaver kidneys to any transplant hospital or by a hospital based OPO.

A transplant hospital that is also a certified organ procurement organization may acquire cadaver kidneys by:

- Having its organ procurement team excise kidneys from cadavers in other hospitals;
- Arrangements with participating community hospitals, whether they excise kidneys on a regular or irregular basis; and

- Arrangements with an organ procurement organization that services the transplant hospital as a member of a network.

When the transplant hospital also excises the cadaver kidney, the cost of the procedure is included in its kidney acquisition costs and is considered in arriving at its standard cadaver kidney acquisition charge. When the transplant hospital excises a kidney to provide another hospital, it may use its standard cadaver kidney acquisition charge or its standard detailed departmental charges to bill that hospital.

When the excising hospital is not a transplant hospital, it bills its customary charges for services used in excising the cadaver kidney to the transplant hospital or organ procurement agency.

If the transplanting hospital's organ procurement team excises the cadaver kidney at another hospital, the cost of operating such a team is included in the transplanting hospital's kidney acquisition costs, along with the reasonable charges billed by the other hospital of its services.

90.1.1 - The Standard Kidney Acquisition Charge

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and

- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on revenue code 081X. Kidney acquisition charges are not considered for the IPPS outlier calculation.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

A. - Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B. - Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C. - Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the A/B MAC (A) at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE:

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

D. - Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E. - Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F. - Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live Kidney Donor and Related Services) appears on the claim. For services performed on or after January 1, 2011 CWF shall allow Edit 5211 to be overridden at the contractor level. Also, contractors shall override Edit 5211 when this modifier appears on claims for donor services it receives when the recipient is deceased (See Publication 100-02, Chapter 11, Section 80.4).

NOTE: For institutional claims, contractors may manually override the CWF edit as necessary.

G. - Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Applicable standard kidney acquisition charges are identified separately by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not** included in the kidney transplant prospective payment. They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for kidney transplant procedure codes. Where these procedure codes are identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

90.1.3 - Billing for Donor Post-Kidney Transplant Complication Services

(Rev. 2334, Issued: 10-28-11; Effective: Policy Effective date: November 28, 2011; Claims Processing Effective date: April 1, 2012; Implementation: April 2, 2012)

Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.

All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor’s transplant discharge will be billed under the recipient’s health insurance claim number and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.

- All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's Medicare number)

- Modifier Q3 (Live Kidney Donor and Related Services) appears on each covered line of the claim that contains a HCPCS code.

Institutional claims will be required to also include:

- Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)

- Patient Relationship Code 39 (Organ Donor)

Contractors shall override Edit 5211 when modifier Q3 appears on claims for donor services it receives when the recipient is deceased (See Pub. 100-02, chapter 11, section 80.4).

NOTE: For institutional claims which do not require modifiers, contractors may manually override the CWF edit as necessary.

90.2 - Heart Transplants

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

If a contractor has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of approved transplant centers, visit:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

A. - Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987. All transplant hospitals will be recertified under the final rule, **Federal Register** / Vol. 72, No. 61 / Friday, March 30, 2007, / Rules and Regulations.

The CMS informs each hospital of its effective date in an approval letter.

B. - Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C. - Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant

from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. - Charges for Heart Acquisition Services

The excising hospital bills the OPO, who in turn bills the transplant (implant) hospital for applicable services. It should not submit a bill to its contractor. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

Acquisition charges shall be billed on a 081X revenue code. Such charges are not considered for the IPPS outlier calculation when billed for a heart transplant.

E. - Bill Review Procedures

The contractor takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1. MCE Interface

The MCE creates a Limited Coverage edit for heart transplant procedure codes. Where these procedure codes are identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

2. Handling Heart Transplant Billings From Nonapproved Hospitals

Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

90.3 - Stem Cell Transplantation

(Rev. 3556, Issued: 07-01-16; Effective: 01-27-16; Implementation: 10-03-16)

A. General

Stem cell transplantation is a process in which stem cells are harvested from either a patient's (autologous) or donor's (allogeneic) bone marrow or peripheral blood for intravenous infusion. Autologous stem cell transplantation (AuSCT) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic hematopoietic stem cell transplantation (HSCT) is a procedure in which a portion of a healthy donor's stem cell or bone marrow is obtained and prepared for intravenous infusion. Allogeneic HSCT may be used to restore function in recipients having an inherited or acquired deficiency or defect. Hematopoietic stem cells are multi-potent stem cells that give rise to all the blood cell types; these stem cells form blood and immune cells. A hematopoietic stem cell is a cell isolated from blood or bone marrow that can renew itself, differentiate to a variety of specialized cells, can mobilize out of the bone marrow into circulating blood, and can undergo programmed cell death, called apoptosis - a process by which cells that are unneeded or detrimental will self-destruct.

The Centers for Medicare & Medicaid Services (CMS) is clarifying that bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. Effective October 1, 1990, these cases were assigned to MS-DRG 009, Bone Marrow Transplant.

The A/B MAC (A)'s Medicare Code Editor (MCE) will edit stem cell transplant procedure codes against diagnosis codes to determine which cases meet specified coverage criteria. Cases with a diagnosis code for a covered condition will pass (as covered) the MCE noncovered procedure edit. When a stem cell transplant case is selected for review based on the random selection of beneficiaries, the QIO will review the case on a post-payment basis to assure proper coverage decisions.

Bone marrow transplant codes that are reported with an ICD-9-CM that is "not otherwise specified" are returned to the hospital for a more specific procedure code. ICD-10-PCS codes are more precise and clearly identify autologous and nonautologous stem cells.

The A/B MAC (A) may choose to review if data analysis deems it a priority.

B. Nationally Covered Indications

I. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

a. General

Allogeneic stem cell transplantation (ICD-9-CM Procedure Codes 41.02, 41.03, 41.05, and 41.08,; ICD-10-PCS codes 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, and 30263Y1) is a procedure in which a

portion of a healthy donor's stem cells are obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect. See Pub. 100-03, National Coverage Determinations (NCD) Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

b. Covered Conditions

i. **Effective for services performed on or after August 1, 1978:**

For the treatment of leukemia, leukemia in remission, or aplastic anemia when it is reasonable and necessary;

ii. **Effective for services performed on or after June 3, 1985:**

For the treatment of severe combined immunodeficiency disease (SCID), and for the treatment of Wiskott-Aldrich syndrome;

iii. **Effective for services performed on or after August 4, 2010:**

For the treatment of Myelodysplastic Syndromes (MDS) pursuant to Coverage with Evidence Development (CED) in the context of a Medicare-approved, prospective clinical study.

iv. **Effective for claims with dates of service on or after January 27, 2016:**

1. Allogeneic HSCT for multiple myeloma is covered by Medicare only for beneficiaries with Durie-Salmon Stage II or III multiple myeloma, or International Staging System (ISS) Stage II or Stage III multiple myeloma, and participating in an approved prospective clinical study.

2. Allogeneic HSCT for myelofibrosis (MF) is covered by Medicare only for beneficiaries with Dynamic International Prognostic Scoring System (DIPSSplus) intermediate-2 or High primary or secondary MF and participating in an approved prospective clinical study.

3. Allogeneic HSCT for sickle cell disease (SCD) is covered by Medicare only for beneficiaries with severe, symptomatic SCD who participate in an approved prospective clinical study.

II. Autologous Stem Cell Transplantation (AuSCT)

a. General

Autologous stem cell transplantation (ICD-9-CM Procedure Codes 41.01, 41.04, 41.07, and 41.09; ICD-10-PCS codes 30230AZ, 30230G0, 30230Y0, 30233G0, 30233Y0, 30240G0, 30240Y0, 30243G0, 30243Y0, 30250G0, 30250Y0, 30253G0, 30253Y0, 30260G0, 30260Y0, 30263G0, and 30263Y0) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

b. Covered Conditions

1. Effective for services performed on or after April 28, 1989:

Acute leukemia in remission who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched;

Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response;

Recurrent or refractory neuroblastoma; or,

Advanced Hodgkin's disease who have failed conventional therapy and have no HLA-matched donor.

2. Effective for services performed on or after October 1, 2000:

Single AuSCT is only covered for Durie-Salmon Stage II or III patients that fit the following requirements:

- Newly diagnosed or responsive multiple myeloma. This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse; and

- Adequate cardiac, renal, pulmonary, and hepatic function.

3. **Effective for services performed on or after March 15, 2005:**

When recognized clinical risk factors are employed to select patients for transplantation, high dose melphalan (HDM) together with AuSCT is reasonable and necessary for Medicare beneficiaries of any age group with primary amyloid light chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and,
- Cardiac left ventricular ejection fraction (EF) greater than 45%.

C. Nationally Non-Covered Indications

I. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

Effective for claims with dates of service on or after May 24, 1996, through January 26, 2016, allogeneic HSCT is not covered as treatment for multiple myeloma. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

II. Autologous Stem Cell Transplantation (AuSCT)

Insufficient data exist to establish definite conclusions regarding the efficacy of AuSCT for the following conditions:

a) Acute leukemia not in remission;
b) Chronic granulocytic leukemia;
c) Solid tumors (other than neuroblastoma);
d) Up to October 1, 2000, multiple myeloma;
e) Tandem transplantation (multiple rounds of AuSCT) for patients with multiple myeloma;
f) Effective October 1, 2000, non primary AL amyloidosis; and,
g) Effective October 1, 2000, through March 14, 2005, primary AL amyloidosis for Medicare beneficiaries age 64 or older.

In these cases, AuSCT is not considered reasonable and necessary within the meaning of §l862(a)(1)(A) of the Act and is not covered under Medicare. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

D. Other

All other indications for stem cell transplantation not otherwise noted above as covered or non-covered remain at local Medicare Administrative Contractor discretion.

90.3.1 - Allogeneic for Stem Cell Transplantation

(Rev. 4271, Issued: 03-29-19, Effective: 04-29-19, Implementation: 04-29-19

A. **Definition of Acquisition Charges for Allogeneic Stem Cell Transplants**

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;

- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);

- Post-operative/post-procedure evaluation of donor; and

- Preparation and processing of stem cells.

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting, and in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the outpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 4, §231.10 and paragraph B of this section for information regarding billing for autologous stem cell transplants).

B. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 4, §231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.

When the allogeneic stem cell transplant occurs in the inpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately by using revenue code 0815 (Stem Cell Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above.

On the recipient’s transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor’s hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

90.3.2 - Autologous Stem Cell Transplantation (AuSCT)

(Rev. 4271, Issued: 03-29-19, Effective: 04-29-19, Implementation: 04-29-19

A. - General

Autologous stem cell transplantation (AuSCT) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

If ICD-9-CM is applicable, use the following Procedure Codes and Descriptions

ICD-9-CM Code	Description
41.01	Autologous bone marrow transplant without purging
41.04	Autologous hematopoietic stem cell transplant without purging
41.07	Autologous hematopoietic stem cell transplant with purging
41.09	Autologous bone marrow transplant with purging

If ICD-10-PCS is applicable, use the following Procedure Codes and Descriptions -

ICD-10-PCS Code	Description
30230AZ	Transfusion of Embryonic Stem Cells into Peripheral Vein, Open Approach
30230G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Open Approach
30230Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Open Approach
30233G0	Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach
30233Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach

ICD-10-PCS Code	Description
30240G0	Transfusion of Autologous Bone Marrow into Central Vein, Open Approach
30240Y0	Transfusion of Autologous Bone Marrow into Central Vein, Open Approach
30243G0	Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach
30243Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach
30250G0	Transfusion of Autologous Bone Marrow into Peripheral Artery, Open Approach
30250Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Open Approach
30253G0	Transfusion of Autologous Bone Marrow into Peripheral Artery, Percutaneous Approach
30253Y0	Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Percutaneous Approach
30260G0	Transfusion of Autologous Bone Marrow into Central Artery, Open Approach
30260Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Open Approach
30263G0	Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach
30263Y0	Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach

B. - Covered Conditions

1. Effective for services performed on or after April 28, 1989:

For acute leukemia in remission for patients who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched, the following diagnosis codes are reported:

If ICD-9-CM is applicable, use the following Diagnosis Codes and Descriptions

Diagnosis Code	Description
204.01	Lymphoid leukemia, acute, in remission
205.01	Myeloid leukemia, acute, in remission
206.01	Monocytic leukemia, acute, in remission

Diagnosis Code	Description
207.01	Acute erythremia and erythroleukemia, in remission
208.01	Leukemia of unspecified cell type, acute, in remission

If ICD-10-CM is applicable, use the following Diagnosis Codes and Descriptions -

Diagnosis Code	Description
C91.01	Acute lymphoblastic leukemia, in remission
C92.01	Acute myeloblastic leukemia, in remission
C92.41	Acute promyelocytic leukemia, in remission
C92.51	Acute myelomonocytic leukemia, in remission
C92.61	Acute myeloid leukemia with 11q23-abnormality in remission
C92.A1	Acute myeloid leukemia with multilineage dysplasia, in remission
C93.01	Acute monoblastic/monocytic leukemia, in remission
C94.01	Acute erythroid leukemia, in remission
C94.21	Acute megakaryoblastic leukemia, in remission
C94.41	Acute parmyelosis with myelofibrosis, in remission
C95.01	Acute leukemia of unspecified cell type, in remission

For resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response the following diagnosis codes are reported:

If ICD-9-CM is applicable, use the following code ranges:

200.00 - 200.08,
200.10 - 00.18,
200.20 - 200.28,
200.80 - 200.88,
202.00 - 202.08,
202.80 - 202.88, and
202.90 - 202.98.

If ICD-10-CM is applicable use the following code ranges:

C82.00 - C85.29,
C85.80 - C86.6,
C96.4, and
C96.Z - C96.9.

For recurrent or refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant for the appropriate diagnosis code)

If ICD-10-CM is applicable the following ranges are reported:
C00 - C96, and
D00 - D09 Resistant non-Hodgkin's lymphomas

For advanced Hodgkin's disease patients who have failed conventional therapy and have no HLA-matched donor the following diagnosis codes are reported:

If ICD-9-CM is applicable, 201.00-201.98.

If ICD-10-CM is applicable, C81.00 - C81.99.

2. Effective for services performed on or after October 1, 2000:

Durie-Salmon Stage II or III that fit the following requirement are covered: Newly diagnosed or responsive multiple myeloma (if ICD-9-CM is applicable, diagnosis codes 203.00 and 238.6, and, if ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9). This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse, and adequate cardiac, renal, pulmonary, and hepatic function.

3. Effective for Services On or After March 15, 2005

Effective for services performed on or after March 15, 2005, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan (HDM), together with AuSCT, in treating Medicare beneficiaries of any age group with primary amyloid light-chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs ; and,
- Cardiac left ventricular ejection fraction (EF) of 45% or greater.

C. - Noncovered Conditions

Insufficient data exist to establish definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- Acute leukemia not in remission:
    - If ICD-9-CM is applicable, diagnosis codes 204.00, 205.00, 206.00, 207.00 and 208.00 are noncovered;
    - If ICD-10-CM is applicable, diagnosis codes C91.00, C92.00, C92.40, C92.50, C92.60, C92.A0, C93.00, C94.00, and C95.00 are noncovered.
- Chronic granulocytic leukemia:
    - If ICD-9-CM is applicable, diagnosis codes 205.10 and 205.11;
    - If ICD-10-CM is applicable, diagnosis codes C92.10 and C92.11.

- Solid tumors (other than neuroblastoma):
    - If ICD-9-CM is applicable, diagnosis codes 140.0-199.1;
    - If ICD-10-CM is applicable, diagnosis codes C00.0 - C80.2 and D00.0 - D09.9.
- Multiple myeloma (ICD-9-CM codes 203.00 and 238.6), through September 30, 2000.
- Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma
    - If ICD-9-CM is applicable, diagnosis codes 203.00 and 238.6 and,
    - If ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9)
- Non-primary (AL) amyloidosis,
    - If ICD-9-CM is applicable, diagnosis code 277.3. Effective October 1, 2000; ICD-9-CM code 277.3 was expanded to codes 277.30, 277.31, and 277.39 effective October 1, 2006.
    - If ICD-10-CM is applicable, diagnosis codes are E85.0 - E85.9. or
- Primary (AL) amyloidosis
    - If ICD-9-CM is applicable, diagnosis codes 277.30, 277.31, and 277.39 and for Medicare beneficiaries age 64 or older, effective October 1, 2000, through March 14, 2005.
    - If ICD-10-CM is applicable, diagnosis codes are E85.0 - E85.9.

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered is left to the discretion of the A/B MAC (A).

D. Billing for Autologous Stem Cell Transplantation (AuSCT)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, in revenue center code 0362 or another appropriate cost center. ICD-9-CM or ICD-10-PCS codes are used to identify inpatient procedures.

The HCPCS codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPPS when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, chapter 4, §231.11 and section 90.3.1-A above for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant. The HCPCS codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for autologous stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

90.4 - Liver Transplants
(Rev. 2513, Issued: 08-03-12, Effective: 06-21-12, Implementation: 09-04-12)

A. Background

For Medicare coverage purposes, liver transplants are considered medically reasonable and necessary for specified conditions when performed in facilities that meet specific criteria. Coverage guidelines may be found in Publication 100-03, Section 260.1.

Effective for claims with dates of service June 21, 2012 and later, contractors may, at their discretion cover adult liver transplantation for patients with extrahepatic unresectable cholangiocarcinoma (CCA), (2) liver metastases due to a neuroendocrine tumor (NET) or (3) hemangioendothelimo (HAE) when furnished in an approved Liver Transplant Center (below). All other nationally non-covered malignancies continue to remain nationally non-covered.

To review the current list of approved Liver Transplant Centers, see http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html

90.4.1 - Standard Liver Acquisition Charge
(Rev. 1, 10-01-03)

A3-3615.1, A3-3615.3

Each transplant facility must develop a standard charge for acquiring a cadaver liver from costs it expects to incur in the acquisition of livers.

This standard charge is not a charge that represents the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with a liver acquisition.

Services associated with liver acquisition are billed from the organ procurement organization or, in some cases, the excising hospital to the transplant hospital. The excising hospital does not submit a billing form to the A/B MAC (A). The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and the potential transplant donor. These charges are reflected in the transplant hospital's liver acquisition cost center and are used in determining the hospital's standard charge for acquiring a cadaver's liver. The standard charge is not a charge representing the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with liver acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a liver, e.g., tissue typing, transportation of organ, and surgeons' retrieval fees.

90.4.2 - Billing for Liver Transplant and Acquisition Services
(Rev. 10002, Issued: 03-20-2020, Effective: 04-20-2020, Implementation: 04-20-2020)

The inpatient claim is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately by revenue code 081X. Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are **not** included in the liver transplant prospective payment. They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code 081X in the HUIP record that it sends to CWF and the QIO.

MCE Interface

The MCE contains a limited coverage edit for liver transplant procedures using ICD-9-CM code 50.59 if ICD-9 is applicable, and, if ICD-10 is applicable, using ICD-10-PCS codes 0FY00Z0, 0FY00Z1, and 0FY00Z2.

Where a liver transplant procedure code is identified by the MCE, the contractor shall check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant, and determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. Contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section 260.1 have been met. If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the contractor denies the claim.

NOTE: Some noncovered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. Do not pay for noncovered conditions.

Grouper

If the bill shows a discharge date before March 8, 1990, the liver transplant procedure is not covered. If the discharge date is March 8, 1990 or later, the contractor processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigned CMS DRG 191 or 192. The contractor sent the bill to Pricer with review code 08. Pricer would then overlay CMS DRG 191 or 192 with CMS DRG 480 and the weights and thresholds for CMS DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns CMS DRG 480 and Pricer is able to price without using review code 08. If the discharge date is after September 30, 2007, Grouper assigns

MS-DRG 005 or 006 (Liver transplant with MCC or Intestinal Transplant or Liver transplant without MCC, respectively) and Pricer is able to price without using review code 08.

Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The contractor will receive a copy of the letter.

90.5 - Pancreas Transplants Kidney Transplants

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

A. - Background

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant if ICD-9 is applicable, ICD-9-CM procedure code 55.69. If ICD-10 is applicable, the following ICD-10-PCS codes will be used:

0TY00Z0,
0TY00Z1,
0TY00Z2,
0TY10Z0.
0TY10Z1, and
0TY10Z2.

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

B. - Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

If ICD-9 Is Applicable

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The contractor must determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

If ICD-10 is applicable, the following procedure codes (ICD-10-PCS) are:

- 0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
- 0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

If ICD-9-CM is applicable, Diabetes Diagnosis Codes and Descriptions

ICD-9-CM Code	Description
250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations

ICD-9-CM Code	Description
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

If ICD-10-CM is applicable, the diagnosis codes are: E10.10 - E10.9

Hypertensive Renal Diagnosis Codes and Descriptions if ICD-9-CM is applicable :

ICD-9-CM Code	Description
403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure
585.1 - 585.6, 585.9	Chronic Renal Failure Code

If ICD-10-CM is applicable, diagnosis codes and descriptions are:

ICD-10-CM code	Description
I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
N18.1	Chronic kidney disease, stage 1

ICD-10-CM code	Description
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
N18.9	Chronic kidney disease, unspecified

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill ICD-9-CM codes 585.1 - 585.6, 585.9 or, if ICD-10-CM is applicable, the diagnosis codes N18.1 - N18.9 on such a patient. In these cases one of the following codes should be present on the claim or in the beneficiary's history.

The provider uses the following ICD-9-CM status codes only when a kidney transplant was performed before the pancreas transplant and ICD-9 is applicable:

ICD-9-CM code	Description
V42.0	Organ or tissue replaced by transplant kidney
V43.89	Organ tissue replaced by other means, kidney or pancreas

If ICD-10-CM is applicable, the following ICD-10-CM status codes will be used:

ICD-10-CM code	Description
Z48.22	Encounter for aftercare following kidney transplant
Z94.0	Kidney transplant status

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a status code to indicate a previous kidney transplant. If the status code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a status code indicating a prior kidney transplant.

C. - Drugs

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D. - Charges for Pancreas Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim. In addition, the contractor remove acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

E. - Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor shall reject the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: B15
RARC: N/A
MSN: 16.32

If no evidence of a prior kidney transplant is presented, then the contractor shall deny the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 50
RARC: MA126
MSN: 15.4

90.5.1 - Pancreas Transplants Alone (PA)

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

A. - General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health

Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

B. - Nationally Covered Indications

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

C. - Billing and Claims Processing

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

Contractors who receive claims for PA services that were performed in an unapproved facility, should reject such claims.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 58
RARC: N/A
MSN: 16.2

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

All-Inclusive List of Covered Diagnosis Codes for PA if ICD-9-CM is applicable

(**NOTE: "**X" = 1 and 3 only)

ICD-9-CM code	**Description**
250.0X	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations

ICD-9-CM code	Description
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

If ICD-10-CM is applicable, , the provider uses the following range of ICD-10-CM codes:

E10.10 – E10.9.

Procedure Codes

If ICD-9 CM is applicable

52.80 - Transplant of pancreas
52.82 - Homotransplant of pancreas

If ICD-10 is applicable, the provider uses the following ICD-10-PCS codes:

0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers ICD-9-CM codes 52.80 and 52.82 and ICD-10-PCS codes 0FYG0Z0 and 0FYG0Z1 as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 50
RARC: N/A
MSN: 15.4

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

D. - Charges for Pancreas Alone Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include PA in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for PA transplantation are billed in Revenue Code 081X. The contractor removes acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 10210, Issued: 07-10-2020, Effective: 08-10-2020, Implementation: 08-10-2020)

A. - Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. - Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

C. - Billing

If ICD-9-CM is applicable, ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. If ICD-10 is applicable, the ICD-10-PCS procedure codes are 0DY80Z0, 0DY80Z1, 0DYE0Z0, and 0DYE0Z1. The Medicare Code Editor (MCE) lists these codes as limited coverage procedures. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For these procedures where the provider is approved as a transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date dependent on patient's age, contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section §260.5 have been met.

If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If ICD-9-CM is applicable, charges for ICD-9-CM procedure code 46.97, and, if ICD-10 is applicable, the ICD-10-PCS procedure codes 0DY80Z0, 0DY80Z1, 0DYE0Z0, or 0DYE0Z1 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September

30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

If ICD-9-CM is applicable, there is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include but are not limited to the following conditions and their associated ICD-9-CM codes:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,
- Volvulus gastroschisis 569.89, other specified disorders of intestine,
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,
- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and
- Radiation enteritis 558.1.

If ICD-10-CM is applicable, some diagnosis codes that may be used for intestinal failure are:

- Volvulus K56.2,
- Enteroptosis K63.4,
- Other specified diseases of intestine K63.89,
- Other specified diseases of the digestive system K92.89,
- Postsurgical malabsorption, not elsewhere classified K91.2,
- Other congenital malformations of abdominal wall Q79.59,

- Necrotizing enterocolitis in newborn, unspecified P77.9,
- Stage 1 necrotizing enterocolitis in newborn P77.1,
- Stage 2 necrotizing enterocolitis in newborn P77.2, and
- Stage 3 necrotizing enterocolitis in newborn P77.3.

D. - Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. Therefore, acquisition charges billed on revenue code 081x are removed from the claim's total covered charges so as to not be included in the IPPS outlier calculation. The Medicare Cost Report will include a separate line to account for these transplantation costs.

For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. - Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 171
RARC: N/A
MSN: 21.6 or 21.18 or 16.2

100 - Billing Instructions for Specific Situations
(Rev. 1, 10-01-03)

100.1 - Billing for Abortion Services
100.1 - Billing for Abortion Services
(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

Effective October 1, 1998**,** abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

A. - "G" Modifier

The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998, and after. CWF will be able to recognize the modifier beginning July 1, 1999.

B. - A/B MAC (A) Billing Instructions

1. **Hospital Inpatient Billing**

Hospitals use bill type 11X. Medicare will pay only when one of the following condition codes is reported:

Condition Code	Description
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AD	Abortion Performed due to life endangering physical condition

With one of the following:

If ICD-9-CM Is Applicable:

- an appropriate ICD principal diagnosis code that will group to DRG 770 (Abortion W D&C, Aspiration Curettage Or Hysterotomy) or
- an appropriate ICD principal diagnosis code and one of the following ICD-9-CM operating room procedure that will group to DRG 779 (Abortion W/O D&C):69.01, 69.02, 69.51, 74.91.

If ICD-10-CM is applicable, one of the following ICD-10-PCS codes are used:

ICD-10-PCS code	Description
10A07ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening
10A08ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic
10D17ZZ	Extraction of Products of Conception, Retained, Via Natural or Artificial Opening
10D18ZZ	Extraction of Products of Conception, Retained, Via Natural or Artificial Opening Endoscopic
10A07ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening
10A08ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic
10A00ZZ	Abortion of Products of Conception, Open Approach
10A03ZZ	Abortion of Products of Conception, Percutaneous Approach

ICD-10-PCS code	Description
10A04ZZ	Abortion of Products of Conception, Percutaneous Endoscopic Approach

Providers must use ICD-9-CM codes 69.01 and 69.02 if ICD-9-CM is applicable, or, if ICD-10-CM is applicable, the related 1CD-10-PCS codes to describe exactly the procedure or service performed.

The A/B MAC (A) must manually review claims with the above ICD-9-CM/ICD-10-PCS procedure codes to verify that all of the above conditions are met.

2. **Outpatient Billing**

Hospitals will use bill type 13X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840	59851	59856
59841	59852	59857
59850	59855	59866

C. - Common Working File (CWF) Edits

For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above inpatient procedure codes.

D. - Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits Remittance Advice Message

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim is denied.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 272
RARC: N/A
MSN: 21.21

100.2 - Payment for CRNA or AA Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

This section discusses reasonable cost-based payment for CRNA services (42 CFR § 412.113(c)). Note that effective January 1, 2013, qualifying rural hospitals and CAHs are

eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Anesthesia services furnished on or after January 1, 1989, and before January 1, 1990, at a rural hospital or CAH by a qualified hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The A/B MAC (A) determines the hospital's qualification using the following criteria:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.

- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

- The hospital or CAH must demonstrate that during the 1987 calendar year, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures.

- Each qualified CRNA or AA employed or under contract with the hospital or CAH must agree in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

In addition to the criteria described above, to maintain eligibility for reasonable cost-based payment for services furnished on or after January 1, 1990, a hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 800 procedures.

If a hospital or CAH did not qualify for reasonable cost-based payment for CRNA or AA services in calendar year 1989, it can qualify in subsequent years if it demonstrates to the Medicare Contractor prior to the start of the calendar year that it met these criteria noted below:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.

- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

- Each qualified CRNA or AA employed or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

- The hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 800 procedures.

Effective for calendar years beginning January 1, 1991, the A/B MAC (A) determines the number of surgical procedures for the immediately preceding year by summing the number of surgical procedures for the 9-month period ending September 30, annualized for a 12-month period.

Effective December 2, 2010, in addition to a hospital or CAH that is located in a rural area (as defined for PPS purposes), a hospital or CAH may be eligible to be paid based on reasonable cost for CRNA or AA services, if the hospital or CAH has reclassified as rural under 42 Code of Federal Regulations 412.103.

To prevent duplicate payments, the A/B MAC (A) informs A/B MACs (B) of the names of CRNAs or AAs, the hospitals and/or CAHs with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished after the hospital's and/or CAH's election of reasonable cost payments, the A/B MAC (B) must recover the overpayment from the CRNA or AA.

Since a swing-bed is a bed that is available for use to provide acute inpatient care or SNF-level care and the CRNA/AA pass-through provision applies to hospital inpatients, CRNA and AA services provided to hospital and CAH swing-bed patients under the pass-through provision must be included on the hospital or CAH swing-bed bill.

100.3 - Resident and Interns Not Under Approved Teaching Programs
(Rev. 1, 10-01-03)

A3-3669

A. - General

A provider's cost for the services furnished by residents and interns not under approved teaching programs (including physicians employed by the provider who are authorized to practice only in a provider setting) are covered under Part B. (Part A covers only the costs of services performed for inpatients by residents and interns who are under approved teaching programs.) See the Medicare Benefit Policy Manual, Chapter 6 for further information on the coverage of these services.

The provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 096X, 097X, or 098X as applicable.

B. - Provider Procedures

The cost of Part B residents' and interns' services to inpatients is calculated on a per diem basis by the hospital in consultation with its A/B MAC (A). The A/B MAC (A) apportions the total cost of such services (including fringe benefits, etc.) between inpatient and outpatient services on the basis of the time spent on each. It obtains the inpatient per diem figure by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For the patients who are enrolled under Part B, regardless of whether Part A benefits are payable, the provider is reimbursed for 80 percent of the cost of providing these services. The provider collects or bills the complementary insurer for 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. The administrative cost of determining Part B deductible status involving the cost of query, response, recording, and accounting on an individual basis in the aggregate, exceeds the potential patient deductible obligation. Therefore, as long as the patient is entitled to Part A benefits no determination of the patient's deductible liability need to be made for inpatient Part B interns' and residents' services.

Patients not enrolled under Part B are liable for the entire cost of intern and resident services. The provider maintains a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of final cost settlement.

C. - A/B MAC (A) Procedures

Its A/B MAC (A) assists the provider in arriving at the inpatient per diem rate for the cost of services covered under Part B provided by residents and interns. (See the Provider Reimbursement Manual, Part I, §2120 for apportioning costs between inpatient and outpatient per diem and §2406 for establishing interim rates.) The normal interim reimbursement rate applied to other provider services applies to Part B residents' and interns' services.

100.4 - Billing for Services After Termination of Provider Agreement
(Rev. 1, 10-01-03)

HO-404, HH-433

An agreement with a hospital is not time-limited and has no fixed expiration date.

A. - Part A Billing

A hospital whose provider agreement terminates (voluntarily or involuntarily), may be reimbursed for covered Part A inpatient services for up to 30 days for services furnished **on or after the effective date of termination** for beneficiaries who were admitted **prior** to the termination date.

EXAMPLE:

Termination date: 6/30/01

Beneficiary admitted on or before 6/29/01

Payment can be made: 6/30/01, up to and including 7/29/01

B. - Assuring That Hospitals Continue to Bill for Covered Services

Upon cessation of a hospital's participation in the program, it supplies the Regional Office the names and HICNs of Medicare beneficiaries entitled to have payment made on their behalf, and continues to bill for covered services in accordance with subsection A. It continues to submit "no-payment" death or discharge bills for Medicare beneficiaries admitted prior to the termination of the provider's agreement.

C. - Part B Billing

Following termination of its agreement, a hospital is considered to be a "nonparticipating hospital." An inpatient of such a hospital who has Part B coverage, but for whom Part A benefits have been exhausted, or are otherwise not available, is entitled to reimbursement for those services that are covered in a nonparticipating institution. Services, if rendered, must be billed on Form CMS-1500 and sent to the A/B MAC (B). If a hospital has been billing on the CMS-1554 for physician services, it continues to do so.

If a terminated hospital meets the necessary criteria, it may be certified to provide emergency services, and will be assigned an emergency provider number (E suffix). This procedure is not automatic, however, and hospitals which are terminated for Life Safety Code violations may never be able to qualify as emergency providers. Should a terminated hospital later qualify as an emergency provider, billings are handled by the designated emergency FI.

100.4.1 - Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number

(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

Where a multiple-facility provider is assigned separate provider numbers for each component facility or where a provider is assigned a different number, it is required to use the new number for all notices of admission, start of care notices, bills, etc., beginning with the date the new number is effective.

A. - Inpatient

The component provider to which the new number is assigned must apportion costs for all patients who are inpatients in that component as of the first day of the next fiscal period when the new provider number goes in effect. The hospital must submit a discharge bill with the old provider number and an admission notice with the new. The date of discharge and the date of admission are the same date, which is the first day of the new fiscal period. All subsequent billings are submitted under the new provider number. If a no-payment situation where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit a discharge bill and admission notice. In this situation, only a final no-payment bill with a discharge date is submitted under the old provider number. Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished **before** the date of change in provider number, the hospital submits one corrected bill covering the entire period showing the old provider number. However, where services subsequently determined to be covered were furnished **after** the date of change, the hospital submits a corrected discharge bill with the old provider number and a new admission notice and billing with the new provider number.

Effective October 1, 2004, there are new rules pertaining to long term care hospitals. (See section 150.14.1).

B. - Outpatient Services, Part B Ancillary Services and Home Health Agency Services

For outpatient services and Part B ancillary services, and home health agency services, the provider uses the old provider number for services provided up through the day before the effective date of the new provider number. Thereafter, it uses the new number when submitting bills.

100.5 - Review of Hospital Admissions of Patients Who Have Elected Hospice Care

(Rev. 1, 10-01-03)

HO-418

Review of admissions to inpatient general hospitals of beneficiaries who have elected hospice care assures that:

- Nonhospice Medicare coverage is provided to those beneficiaries only when the hospitalization was for a condition not related to the terminal illness, and

- When inpatient hospital services were provided as a hospice benefit, the services rendered were stipulated in the individual's plan of care as established by the hospice's interdisciplinary group.

A. - Review for Nonrelated Hospital Admissions

To assure that nonhospice Medicare coverage is provided to beneficiaries who have elected hospice care only when hospitalization was for a condition not related to the terminal illness, the medical review agent reviews all inpatient hospital claims for these beneficiaries. Appropriate medical records will be requested and a determination made as to whether or not services were related to the individual's terminal illness.

Many illnesses may occur when an individual is terminally ill which are brought on by the patient's underlying condition. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of a weakened condition. Similarly, the setting of bones after fractures which occur in a bone cancer patient would be treatment of a related condition.

If the review reveals hospitalization to be unrelated to the individual's terminal illness, a determination as to the medical necessity and appropriateness of the admission is made. Payment will be totally denied or totally approved based on the finding. If, after review, the admission should have been totally denied, consideration under the limitation of liability provision (§1879 of the Act) applies.

If the review of medical records reveals hospitalization to be related to the individual's terminal illness, the claim is denied as services waived through the hospice election. Limitation on liability provision does not apply.

B. - Review for Related Hospital Admissions

To assure that beneficiaries who have elected hospice care are receiving services as provided in the plans of care established by the hospice's interdisciplinary groups, the medical review agent reviews all inpatient hospital claims submitted by the hospice for these beneficiaries. Appropriate medical records (including the plans of care) are requested and a determination made as to whether or not services provided were related to the individual's terminal illness and stipulated in the plan of care.

If the review reveals that services provided were medically necessary and appropriate for the control of pain or acute or chronic symptom management as outlined in the individual's plan of care, the claim is approved.

If the review reveals that services provided to the hospice beneficiary were not stipulated in the plan of care as established by the hospice's interdisciplinary group, the claim is denied. Limitation on liability does not apply.

100.6 - Inpatient Renal Services
(Rev. 1, 10-01-03)

HO-E400

Section 405.103l of Subpart J of Regulation 5 stipulates that only approved hospitals may bill for ESRD services. Hence, to allow hospitals to bill and be reimbursed for inpatient dialysis services furnished under arrangements, both facilities participating in the arrangement must meet the conditions of 405.2120 and 405.2160 of Subpart U of Regulation 5. In order for renal dialysis facilities to have a written arrangement with each other to provide inpatient dialysis care both facilities must meet the minimum utilization rate requirement, i.e., two dialysis stations with a performance capacity of at least four dialysis treatments per week.

Dialysis may be billed by an SNF as a service if: (a) it is provided by a hospital with which the facility has a transfer agreement in effect, and that hospital is approved to provide staff-assisted dialysis for the Medicare program; or (b) it is furnished directly by an SNF meeting all nonhospital maintenance dialysis facility requirements, including minimum utilization requirements. (See §§1861(h)(6), 1861(h)(7), title XVIII.)

100.7 - Lung Volume Reduction Surgery
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, “National Coverage Determinations”.

The Medicare Code Editor (MCE) creates a Limited Coverage edit for ICD-9-CM procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the A/B MAC (A) shall determine if coverage criteria is met and override the MCE if appropriate.

Effective with the implementation of ICD-10 there will not be an MCE edit for lung volume reduction surgery.

The LVRS can only be performed in the facilities listed on the following Web site: http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Volume-Reduction-Surgery-LVRS.htmlMedicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study was limited to 18 hospitals, and patients were randomized into two arms, either medical management and LVRS or medical management. The study was conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Hospital claims for patients in the NETT were identified by the presence of Condition Code EY. The JHU instructed hospitals of the correct billing procedures for billing claims under the NETT.

100.8 – Replaced Devices Offered Without Cost or With a Credit
(Rev. 2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-12)

Background

To identify and track claims billed for replacement devices, CMS issued CR 4058 on November 4, 2005. This CR provided instructions for billing and processing claims with the following condition codes:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

Policy

Beginning with discharges on or after October 1, 2008, CMS reduces Medicare payment when a replacement device is received by the hospital at a reduced cost or with a credit that is 50 percent or greater than the cost of the device, and when the assigned MS-DRG for the claim is one of the MS-DRGs applied to this policy.

For a list of MS-DRGs for which this policy applies to, please see the IPPS Final Rule.

This adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay.

Billing Procedures (Discharges on or after October 1, 2008)

To correctly bill for a replacement device that was provided with a credit or no cost, hospitals must use the combination of condition code 49 or 50, along with value code FD. The condition code 49 or 50 will identify a replacement device while value code FD will communicate to Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.

Payment (Discharges on or after October 1, 2008)

Medicare deducts the partial/full credit amount, reported in the amount for value code FD, from the final IPPS reimbursement when the assigned MS-DRG is one of the MS-DRGs applied to this policy.

Reminder about Charging for 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 credit for a replacement medical device, the charges to Medicare should also be appropriately reduced.

100.9 – Requirements for Processing Non Veterans Administration (VA) Authorized Inpatient Claims

(Rev. 3779, Issued: 05-24-17, Effective: 10-01-13, Implementation: 04-03-17)

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA- eligible beneficiary chooses to receive services in a Medicare Certified Facility for which the VA has not authorized, the facility shall use Condition Code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days.

130 - Coordination With the Quality Improvement Organization (QIO)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Instructions regarding hospital interactions with QIOs have been relocated as follows:

- Instructions regarding HINNs are found in CMS Transmittal 594, which precedes the placement of full instructions in Chapter 30.

- Instructions regarding hospital billing for cases involving QIO review can be found in Chapter 1, section 150.2.

- Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Social Security Act (the Act) authorizes the implementation of a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital now jointly referred to as inpatient rehabilitation facilities (IRFs).

The IRF PPS is effective for cost reporting periods beginning on or after January 1, 2002. IRF PPS payment rates include all costs of furnishing covered IRF services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR, select the applicable year. Then select Title 42, Chapter IV. Select the TOC for Section 413 and choose §413.75 and §413.85 for educational activities. You may also search the TOC for bad debts, and other costs not covered under the PPS.

Effective for cost reporting periods beginning on or after October 1, 2004, the Medicare Modernization Act of 2003, Public Law 108-173, section 405(g) established that CAHs may open rehabilitation distinct part units. These IRFs will also be paid under the IRF PPS.

140.1 - Medicare IRF Classification Requirements

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system (PPS) under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Section 1886(d)(1)(B)(ii) of the Act gives the Secretary the discretion to define an IRF. The regulations at 42 CFR §§ 412.25 and 412.29 specify the criteria for a provider to be excluded from the inpatient prospective payment system (IPPS) specified in 42 CFR §412.1(a)(1) and instead be paid under the IRF PPS.

A facility paid under the IRF PPS is always subject to verification that it continues to meet the criteria for exclusion from the IPPS. The fiscal intermediary (FI) or the Part A/B Medicare Administrative Contractor (MAC) provides the Regional Office (RO) with data for determining the classification status of each facility and the RO reviews the IRF's classification status each year. A determination that a facility either is or is not classified as an IRF takes effect only at the start of a facility's cost reporting period and applies to that entire cost reporting period. If a facility fails to meet the criteria necessary to be paid under the IRF PPS, but meets the criteria to be paid under the IPPS, it may be paid under the IPPS.

If a patient is admitted to a facility that is being paid under the IRF PPS, but is discharged from the facility when it is no longer being paid under the IRF PPS, then payment to the facility will be made from the applicable payment system that is in effect for the facility at the time the patient is discharged.

IRFs that are being paid under the IRF PPS need not reapply to be classified for payment under the IRF PPS each year. However, under CMS's new attestation process, an IRF must self-attest to meeting all of the criteria, except for the criteria specified below in §140.1.1B-D, for being excluded from the IPPS and paid under the IRF PPS every 3 years. The A/B MACs (A) are responsible for verifying annually that each IRF meets the criteria specified below in §140.1.1B-D. IRFs are notified in writing by the ROs of the required self-attestation procedures and the time-frames for submitting the required self-attestation forms. The ROs will also notify the IRFs in writing of any other procedures and requirements that apply to them. However, the A/B MACs (A) are not responsible for monitoring or enforcing the IRF self-attestation procedures, which are the responsibility of the State agencies.

All IRFs must notify their A/B MACs (A) and ROs in writing before making any changes to their operations (i.e. increasing their bed size or square footage, moving to a new location, changing ownership, merging, or other similar changes to the ownership or operations of the facility).

140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Facilities

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

An inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) is excluded from the IPPS and is eligible for payment under the IRF PPS if it meets all of the criteria listed below. Note that in order for an individual IRF claim to receive Medicare payment under the IRF PPS, it must meet all of the IRF coverage requirements in 42 CFR 412.622(a)(3), (4), and (5), as further clarified in Chapter 1, Section 110 of the Medicare Benefit Policy Manual (Pub. 100-02.

A. - The IRF must have (or be part of a hospital that has) a provider agreement under 42 CFR Part 489 to participate in Medicare as a hospital.

B. - During the most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the A/B MAC (A)) the IRF must have treated an inpatient population that met or exceeded the following percentages:

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

C. - List of Medical Conditions:

1. Stroke.

2. Spinal cord injury.

3. Congenital deformity.

4. Amputation.

5. Major multiple trauma.

6. Fracture of femur (hip fracture).

7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

9. Burns.

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course (as defined below) of outpatient therapy services or services in other less intensive rehabilitation settings, but have the potential to improve with more intensive rehabilitation.

11. Systemic vasculidites with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course (as defined below) of outpatient therapy services or services in other less intensive rehabilitation settings, but would have the potential to improve with more intensive rehabilitation.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course (as defined below) of outpatient therapy services or services in other less intensive rehabilitation settings, but would have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

13. Knee or hip joint replacement, or both, during a hospitalization immediately preceding the IRF stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

<u>Definition of "an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings"</u>

For the medical conditions specified above in subsections 10, 11, and 12, an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the A/B MAC (A)'s judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the A/B MAC (A) has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the A/B MAC (A) considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the A/B MAC (A) with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. The outpatient therapy services (or services in other less intensive settings) must immediately precede the IRF admission or result from a systemic disease activation immediately before admission.

The A/B MAC (A) has the discretion to review documentation to assure that the patient has completed an appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. CMS expects that the IRF will obtain copies of the therapy notes from the outpatient therapy or from the therapy services provided in another less intensive setting and include these in the patient's medical record at the IRF (in a section for prior records). CMS believes that these prior records will be used by therapists and others caring for the patient in the IRF, and will also be available to the A/B MAC (A) staff who review the medical records for compliance with the requirements specified above in §140.1.1B-D.

D. - Comorbidities.—A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis. A patient with a comorbidity may be counted as part of the inpatient population that counts towards the required applicable percentage specified above in §140.1.1B-D if:

1. The patient is admitted for inpatient rehabilitation for a medical condition that is not one of the conditions specified above in sub-section 140.1.1C.

2. The patient has a comorbidity that falls in one of the medical conditions specified above in sub-section 140.1.1C; and

3. The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IRF PPS.

E. - For the first cost reporting period during which a facility first begins being paid under the IRF PPS as a "new" IRF, a facility seeking to be paid under the IRF PPS must provide a written certification to the A/B MAC (A) that the inpatient population it intends to serve

meets the requirements specified above in §140.1.1B-D. However, if CMS discovers that the facility did not actually meet the requirements specified above in §140.1.1B-D during any cost reporting period for which the facility provided such written certification of its intent to meet the requirements in §140.1.1B-D, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.9.

F. - The IRF has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

G. - The IRF has in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

H. - The IRF furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

I. - The IRF has one physician who serves as director of rehabilitation and who—

(1) Provides services to the IRF hospital or its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

If an IRF serves both inpatients and outpatients, the time spent by the director in performing administrative duties for the entire facility counts toward the direction requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

J. - The IRF has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

K. - The IRF uses a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans. The IRF must also ensure that team conferences are held at least once per week to determine the appropriateness of treatment.

140.1.2 - Additional Criteria That Must Be Met By Inpatient Rehabilitation Units

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

In addition to the requirements specified above in §140.1.1, an inpatient rehabilitation unit must meet the additional criteria in paragraphs A through M below in order to be excluded from the IPPS and be paid instead under the IRF PPS.

A. - The inpatient rehabilitation unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the IPPS.

B. - The inpatient rehabilitation unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. - The inpatient rehabilitation unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. The record must indicate the dates of the admission and discharge for patients of the unit. The IRF must also have a process in place to ensure that each patient's medical record at the IRF meets the hospital conditions of participation in 42 CFR Part 482 and all of the documentation requirements specified in 42 CFR §412.622 (a)(3), (4), and (5). Further guidance on the IRF documentation requirements is available in chapter 1, section 110 of the Medicare Benefit Policy Manual (Pub. 100-02). The inpatient rehabilitation unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the inpatient rehabilitation unit, as described further in chapter 1, section 110.1.1 of the Medicare Benefit Policy Manual (Pub. 100-02).

D. - If state law provides special licensing requirements for rehabilitation units, the inpatient rehabilitation unit must be licensed in accordance with the applicable requirements.

E. - The hospital's utilization review plan must include separate standards for the type of care offered by the inpatient rehabilitation unit.

F. - The beds assigned to the inpatient rehabilitation unit must be physically separate from (i.e., not co-mingled with) beds not included in the unit. This means that patients from other parts of the hospital may not be treated in the beds assigned to the inpatient rehabilitation unit.

G. - The hospital must have enough beds not excluded from the IPPS to permit the provision of adequate cost information. The A/B MAC (A) has discretion as to how to apply generally accepted accounting principles when making this analysis.

H. - The inpatient rehabilitation unit and the hospital in which it is located must be serviced by the same A/B MAC (A).

I. - The inpatient rehabilitation unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. - The accounting system of the hospital in which the inpatient rehabilitation unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

Compliance with the criteria in items H, I, and J above may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the A/B MAC (A), that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion from the IPPS, if approved, applies.

K. - The cost report for the hospital must include the costs of the inpatient rehabilitation unit, covering the same fiscal period as the hospital, and use the same method of cost apportionment as the hospital.

L. - As of the first day of the first cost reporting period for which all other exclusion requirements are met, the inpatient rehabilitation unit must be fully equipped, staffed, and must be capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. - Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the IPPS.

The criteria specified in paragraphs A through M above are used to determine whether a part of a hospital qualifies for exclusion from the IPPS. An excluded unit must be established as a separate cost entity for cost reporting purposes.

If a hospital wishes to have a unit excluded from the IPPS for a cost reporting period, it must notify its A/B MAC (A), no later than 5 months prior to the start of that cost reporting period, of the following: (1) the particular areas that it has designated as the unit, and (2) the square footage and number of beds in the unit. The A/B MAC (A) or RO will inform the IRF of the proper procedures. The hospital's notification of its intent to have a unit excluded from the IPPS must be sent to the A/B MAC (A) at the same time that it is sent to the RO, and it must identify the designated space for the excluded unit through the use of room numbers and/or bed numbers. The RO will then determine, based on information obtained from the State Survey Agency and the hospital's A/B MAC (A), whether the unit qualifies for exclusion from the IPPS. If the RO rejects the hospital's request to have the unit excluded from the IPPS, it will notify the A/B MAC (A), CMS, and the hospital prior to the start of the hospital's next cost reporting period. If the RO approves the hospital's request to have the unit excluded from the IPPS, it will notify the hospital prior to the start of the hospital's next cost reporting period, and will also notify the A/B MAC (A) of the unit's exclusion from the IPPS and of the unit's new provider identification number.

The hospital must self-attest that it meets all of the applicable criteria for having a unit that is excluded from the IPPS. This self-attestation is subject to verification by the RO, the State Agency, and the A/B MAC (A).

After the initial classification as an IRF, changes in the amount of space occupied by the unit, or in the number of beds in the unit, are allowed to be made one time during a cost reporting period if the hospital notifies its Medicare contractor and the RO in writing of the planned change at least 30 days before the date of the change. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the remainder of that cost reporting period.

140.1.3 - Verification Process Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria

(Rev. 4038, Issued: 04-27-18, Effective: 04-23-18, Implementation: 04- 23-18)

A. - Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period. In general, the RO and A/B MAC (A) will use data from the most recent, consecutive, and appropriate 12-month time period (as defined by CMS) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and A/B MAC (A) will notify the facility of the time period that will be used. The RO and A/B MAC (A) will begin reviewing data 4 months prior to the start of the facility's next cost reporting period.

The compliance review periods are determined based on the following:

1. Guidelines for Determining Compliance Review Periods For IRFs With Cost Reporting Periods That Start Between July 1, 2004 and October 31, 2004.

   Data prior to July 1, 2004 will not be used to determine an IRF's compliance with the requirements in §140.1.1B-D. Thus, for IRFs with cost reporting periods beginning on or after July 1, 2004 and before November 1, 2004, less than 12 months of data will be used in their first compliance review period after July 1, 2004. Refer to the first 5 rows of the Table of Compliance Review Periods (below) for an illustration of this.

2. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Differs Across Two Cost Reporting Periods

   When a cost reporting period starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods, the compliance percentage is calculated using either of the following two methods. The IRF must have a patient population in each of the two portions of time in order to use either of the two methods described below.

   (A) The IRF must meet the applicable compliance percentage threshold in each of the two portions of the compliance review period separately, as illustrated in the example below.

   The following is an example of how this first method would be applied:

   The compliance review period for an IRF that has a cost reporting period from July 1, 2005 through June 30, 2006 is March 1, 2005 to February 28, 2006.

   The IRF must meet a compliance threshold of 50 percent for the cost reporting period of July 1, 2004 to June 30, 2005.

   The IRF must meet a compliance threshold of 60 percent for the cost reporting period of July 1, 2005 to June 30, 2006.

In this example, the first portion of the compliance review period (from March 1, 2005 to June 30, 2005) is part of the IRF's cost reporting period that started on July 1, 2004 and ends on June 30, 2005. The second portion of the compliance review period (from July 1, 2005 to February 28, 2006) is part of the IRF's cost reporting period that starts on July 1, 2005 and ends on June 30, 2006.

Therefore,

For the portion of the compliance review period from March 1, 2005 to June 30, 2005, the compliance percentage threshold that the IRF must meet is 50 percent.

For the portion of the compliance review period from July 1, 2005 to February 28, 2006, the compliance percentage threshold that the IRF must meet is 60 percent.

If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005 to June 30, 2005 portion of the compliance review time period, or the compliance percentage threshold of 60 percent for the July 1, 2005 to February 28, 2006 portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005 to February 28, 2006.

(B) The A/B MAC (A) computes one weighted average compliance percentage for the entire 12-month compliance review period. The resulting weighted average compliance percentage will be used to determine if the facility met the compliance threshold requirements in §140.1.1B-D.

The following is an example of how this second method would be applied: The

compliance review period for an IRF that has a cost reporting period from

August 1, 2005 to July 31, 2006 is April 1, 2005 to March 31, 2006. However, the compliance review period is divided into two portions: April 1, 2005 to July 31, 2005 and August 1, 2005 to March 31, 2006.

In the following hypothetical example, 45 percent of the cases met at least one of the medical conditions listed above in §140.1.1C from April 1, 2005 to July 31, 2005, and 80 percent of the cases met at least one of the medical conditions listed in §140.1.1C from August 1, 2005 to March 31, 2006. The weighted average compliance percentage from the two portions of time must be calculated as follows for compliance review periods beginning on or after January 1, 2013.

4/12 = 0.333 which is rounded to 0.33
8/12 = 0.666 which is rounded to 0.67

0.33 X 45% = 0.1485

0.67 X 80% = 0.5360

0.1485 + 0.5360 = 0.6845 which is rounded to 68%

Based on this result of 68 percent from the weighted average calculation, it will be determined that the IRF met the compliance percentage threshold for the compliance review period starting on April 1, 2005.

3. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Is the Same for the Entire Compliance Review Period

To minimize the level of effort required by Medicare contractors and IRFs, contractors must review one continuous 12-month period if the compliance percentage threshold is the same throughout the entire compliance review period for all compliance review periods beginning on or after January 1, 2013.

4. Guidelines for Determining the Compliance Review Period of a Facility Classified as a New IRF. According to the regulations in §412.25(c), a new IRF can only begin being paid under the IRF PPS at the start of a cost reporting period. If the IRF begins treating patients prior to the start of a cost reporting period, it may receive payment under the IPPS until the start of the next cost reporting period, at which point it can begin receiving payment under the IRF PPS if it meets all of the applicable requirements in §412.25 and §412.29. A new IRF will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2012 and is a new IRF, its compliance review period would start on July 1, 2012 and end on February 28, 2013. Thus, a facility classified as a new IRF will have an initial compliance review period that is 8 months in length, in order to allow the RO and A/B MAC (A) a 4-month time period to make and administer a compliance determination.

5. Guidelines for Determining an IRF's Compliance When the IRF Expands its Bed Capacity. Effective October 1, 2011, as long as an IRF meets all of the applicable requirements in §412.25(b) and 412.29(c)(2), it may add new beds one time, at any time, during a cost reporting period. The IRF must provide written certification that the inpatient population it intends to serve (including the patients served in the new beds) meets the requirements in §412.29(b). In addition, the new IRF beds will be included in the compliance review calculations under§412.29(b) from the time that they are added to the IRF.

6. Guidelines for Determining the Compliance Review Period of a Facility That Changes Its Cost Reporting Period. A facility that changes its cost reporting period will have a new compliance review period that is based on its new cost reporting period. For example, if an IRF changes the start of its cost reporting period from July 1, 2011 to October 1, 2011, then the start date of its compliance review period

will also change from March 1, 2011 to June 1, 2011. Excessive changes to cost reporting periods are not permitted.

The table below entitled "Examples of Compliance Review Periods" provides examples of compliance review periods associated with various cost reporting periods.

Examples of Compliance Review Periods. For a facility that has been classified as an IRF, but is not a "new" IRF as defined below in §140.1.4, the following table provides examples of the compliance review periods associated with different cost reporting periods.

Examples of Compliance Review Periods

Start Date of the Cost Reporting Period for Which a Facility Will (or Will Not) be Classified (or Retain Classification) as an IRF	**Compliance Review Period: (Admissions or Discharges During)**	**# of Months in Review Period**	**Compliance Percentage Threshold**
07/01/2005	07/01/2004 - 02/28/2005	8	50%
08/01/2005	07/01/2004 - 03/31/2005	9	50%
09/01/2005	07/01/2004 - 04/30/2005	10	50%
10/01/2005	07/01/2004 - 05/31/2005	11	50%
11/01/2005	07/01/2004 - 06/30/2005	12	50%
07/01/2006	03/01/2005 - 02/28/2006	12	03/01/2005 to 06/30/2005: 50 % 07/01/2005 to 02/28/2006: 60 %
08/01/2006	04/01/2005- 03/31/2006	12	04/01/2005 to 07/31/2005: 50 % 08/01/2005 to 03/31/2006: 60 %
09/01/2006	05/01/2005- 04/30/2006	12	05/01/2005 to 08/31/2005: 50 % 09/01/2005 to 04/30/2006: 60 %
10/01/2006	06/01/2005- 05/31/2006	12	06/01/2005 to 09/30/2005: 50 % 10/01/2005 to 05/31/2006: 60 %
11/01/2006	07/01/2005- 06/30/2006	12	07/01/2005 to 10/31/2005: 50 % 11/01/2005 to 06/30/2006: 60 %
12/01/2006	08/01/2005- 07/31/2006	12	08/01/2005 to 11/30/2005: 50% 12/01/2005 to 07/31/2006: 60%

For cost reporting periods beginning on or after July 1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs, as described in section 140.3.4 above), the compliance review period will be one continuous 12-month time period beginning 4 months before the start of a cost reporting period and ending 4 months before the beginning of the next cost reporting period.

B. - Types of Data Used to Determine Compliance with the Classification Criteria

1. Starting on July 1, 2004, the A/B MAC (A) will use the verification procedures specified below in subsection C which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records" or subsection D which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population" to verify that an IRF has complied with the requirements specified above in §140.1.1B-D.

2. The verification procedure specified below in subsection C (that is, verification using the IRF-PAI data) will only be used if the A/B MAC (A) has verified that the IRF's Medicare Part A fee-for-service inpatient population is at least 50 percent of the IRF's total inpatient population. Effective for compliance review periods beginning on or after October 1, 2009, A/B MACs (A) must include the IRF's Medicare Part C (Medicare Advantage) inpatient population, along with the IRF's Medicare Part A fee- for-service inpatient population, in determining whether at least 50 percent of the IRF's total inpatient population is made up of Medicare patients.

3. General Guideline Regarding Submission of a List of the Inpatients in Each IRF: In order to verify that an IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient populations (combined) reflect the IRF's total inpatient population, the A/B MAC (A) in writing will instruct the IRF to send the A/B MAC (A), by a specific date, a list showing the hospital patient number of each inpatient IRF admission during the IRF's 12-month compliance review period. Note that the term "hospital patient number" used throughout this section refers to a unique patient identifier used internally within the hospital for patient identification and record-keeping purposes. For each inpatient on the list, the IRF must include the payer the IRF can bill, or has billed, for treatment and services furnished to the inpatient. If an inpatient on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient on the list, the IRF must include the IRF admission and discharge dates.

Exception to the General Guideline: The Secretary of Health and Human Services can declare a Public Health Emergency under section 319 of the Public Health Service Act or another appropriate statute, and the President can declare either a National Emergency under the National Emergencies Act or a Major Disaster under the RobertT. Stafford Disaster Relief and Emergency Assistance Act, or other appropriate law. In accordance with such declarations, certain regulations or operational policies may bewaived in specific geographic areas for limited and defined periods of time. If applicable, in accordance with the waiver provisions, the IRF may be permitted to admit patients (referred to in this section as national emergency or disaster inpatients) who otherwise would be admitted to another inpatient setting. The national emergency or disaster inpatients will not be included as part of the IRF's total inpatient population when the IRF's compliance with the requirements specified in§140.1.1B-D is determined by the A/B MAC (A) reading a sample of medical records. Therefore, when the IRF submits the list of hospital patient numbers stipulated above in section 140.1.3B3, the IRF will identify each national emergency or disaster inpatient by placing either the capital letter "E" or "D" after the patient's unique internal hospital identification number. The A/B MAC (A) will verify the information and, if appropriate, exclude these patients from the list of inpatients used to select a sample of medical records. The IRF should appropriately document in the medical record sufficient information to identify an inpatient as a national emergency or disaster inpatient.

4. The A/B MAC (A) will use the list of hospital patient numbers to determine the IRF's total inpatient population during the IRF's compliance review period. The A/B MAC (A) will then determine whether the compliance percentage threshold differs or is the same throughout the IRF's compliance review period.If the compliance percentage threshold differs during the compliance review period (i.e., if it is 50 percent for one portion of the period and 60 percent for the other portion), then the A/B MAC (A) must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service patients for both time periods. For example, the A/B MAC (A) will consider the portion of the period in which the compliance percentage threshold is 50 percent and the portion of the period in which the compliance percentage threshold is 60 percent independently and determine if the IRF's total inpatient population consists of at least 50 percent Medicare Part A fee-for-service patients in each of the two time periods.

If, however, the compliance percentage threshold is the same throughout the IRF's compliance review period (i.e., 60 percent throughout the period), then the A/B MAC

(A) must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patients (beginning on or after October 1, 2009) for the entire 12-month period.

In addition to the above processes, the A/B MAC (A) has the discretion to sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) population (beginning on or after October 1, 2009) is representative of the IRF's total inpatient population.

A determination by the A/B MAC (A), in accordance with the preceding methodologies, that the IRF's inpatient population for the compliance review period consisted of at least 50 percent Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients (beginning on or after October 1, 2009) means that the A/B MAC (A) can use the procedure stipulated below in subsection C to presumptively determine if the IRF met the compliance threshold as specified above in §140.1.1B-D.

5. The A/B MAC (A) will inform the RO if an IRF fails to send the list showing the hospital patient number associated with each inpatient IRF admission during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. Further, the A/B MAC (A) will inform the RO if the list of hospital patient numbers does not show the payer or payers or the admission and discharge dates for each hospital patient number on the list. The RO will notify the IRF that failure to send the A/B MAC (A) the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D and the facility will no longer be eligible for payment under the IRF PPS.

C. - Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records (The Presumptive Methodology)

1. To determine if a facility has presumptively complied with the criteria specified above in §140.1.1B-D, the CMS will enable the A/B MAC (A) to access the CMS' IRF-PAI data records. Specifically, each A/B MAC (A) will be allowed to access

only the IRF-PAI information submitted by IRFs that submit claims to that A/B MAC (A).

In order to ensure that the software that matches each IRF to a particular A/B MAC (A) is constantly updated, the A/B MAC (A) must electronically send the RO a table that has at least the following title and column headings:

A/B MAC (A) List Of IRF Provider Numbers (Specify The A/B MAC (A)'s Name)

The Name of Each IRF That Submits Claims To This A/B MAC (A)	IRF Provider Number	IRF Cost Reporting Period

After checking the A/B MAC (A)'s list of IRFs for completeness and, as necessary, communicating with the A/B MAC (A) to ensure the accuracy of the information, the RO will forward the A/B MAC (A)'s list of IRFs to the CMS designated mailbox IRFACTIVEPROVIDER@cms.hhs.gov. The CMS contractor that maintains the IRF-PAI database will then, if necessary, update the IRF-PAI database software used to presumptively verify compliance with the requirements specified in §140.1.1B-D. The A/B MAC (A) must coordinate with their CMS RO to obtain access to the software system.

The A/B MAC (A) will provide the RO with user information from all A/B MAC (A) staff that are required to access the IRF-PAI data records.

2. When the A/B MAC (A) accesses the IRF-PAI data records, the A/B MAC (A) will be able to generate an IRF compliance review report using the IRF-PAI information from the IRFs on the A/B MAC (A)'s list. The CASPER software used to generate the IRF compliance review report will automatically use the specific diagnosis codes from the appropriate files listed in "Presumptive Methodology Files – Implementation of Changes" that is attached to the "IRF Compliance Rule Specification Files," which are available for download from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html, to determine if a particular IRF is presumptively in compliance with the requirements specified in §140.1.1B-D. Prior to generating the IRF compliance review report, the A/B MAC (A) must allow the IRF

to decide whether the IRF compliance review report will be generated using the IRF-PAI data records of patients who were admitted during the IRF's compliance review period (even if they were discharged outside of the compliance review period), or the IRF-PAI data records of patients who were discharged during the IRF's compliance review period (even if they were admitted outside of the compliance review period).

Below are the sections of the IRF compliance review report with example data: IRF Compliance Review Report

State	Provider Number	Provider Name	Cost Report Start Date	Compliance Review Period
Any State	IRF Number	Best Rehab	08/01/2008	04/01/2007 To 03/31/2008

Submitted Assessments	Eligible Assessments	Percent
100	60	60%

The submitted assessments section identifies all of the IRF-PAI data records that the IRF submitted to the IRF-PAI database during the compliance review period. The eligible assessments are the assessments submitted during the compliance review period that match one of the codes in the appropriate files listed in "Presumptive Methodology Files – Implementation of Changes" that is attached to the IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html. The cost report start date shown is the start of the facility's next cost reporting period.

3. If an IRF's inpatient Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined) (beginning on or after October 1, 2009) are at least 50 percent of its total inpatient population and the presumptive methodology (described above) indicates that the IRF met or exceeded the requirements specified in §140.1.1B-D, then the IRF is presumed to have met the requirements specified above in §140.1.1B-D. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B-D, the RO and A/B MAC (A) still have the discretion to instruct the IRF to send to the RO or A/B MAC (A) specific sections of the medical records of a random sample of inpatients,

or specific sections of the medical records of inpatients identified by other means by the CMS or the A/B MAC (A).

4. Each A/B MAC (A) must submit a report to the appropriate CMS RO (with a copy to the CMS Central Office) on at least a quarterly basis that shows each IRF's status with respect to compliance with the requirements specified above in §140.1.1B-D.

The files listed in "Presumptive Methodology Files – Implementation of Changes" that is attached to the IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for- Service- Payment/InpatientRehabFacPPS/Criteria.html, will be used to determine presumptive compliance with the requirements specified above in §140.1.1B-D.

D. – Additional Verification of Arthritis Condition Criteria

Compliance with the regulatory requirements for the arthritis conditions specified above in

§140.1.1 B-D cannot be determined by the presence of an impairment group code or diagnosis code alone, but can only be verified through review of the IRF medical record. For this reason, we removed arthritis impairment group codes and diagnosis codes from the list of codes used to determine presumptive compliance for compliance review periods beginning on or after October 1, 2015. However, beginning on or after October 1, 2015, we also provided for an additional item on the IRF-PAI (item #24A) to enable IRFs to indicate whether the patient's arthritis condition(s) meets all of the relevant regulatory requirements specified in §140.1.1 B-D. Using the process described below, the A/B MAC (A) must verify through medical review whether the IRF cases that would not otherwise meet the compliance criteria, and that have a "1 – Yes" marked in item #24A, meet the severity and prior treatment requirements in §140.1.1B-D. If so, then the A/B MAC (A) must add the appropriate number of these cases to the cases that meet the presumptive compliance criteria.

The A/B MAC (A) shall use the following process for compliance review periods beginning on or after October 1, 2015:

1. If the A/B MAC (A) has determined, using the process outlined in subsection C above, that the IRF does not presumptively meet the requirements specified above in §140.1.1B-D, then the A/B MAC (A) must access an IRF-PAI data report called the IRF Arthritis Verification Report through the CASPER system.

Below are the sections of the IRF Arthritis Verification Report with example data:

IRF Arthritis Verification Report

Provider Number	Provider Name	Patient Name	Patient ID	IRF-PAI ID	Admission Date	Discharge Date
	Best Rehab	A. Smith B. Jones Z. Honey	12345678A 22345678A 32345678A	987654321 987654322 987654323	10/1/15 10/2/15 10/3/15	10/15/15 10/14/15 10/13/15

2. The A/B MAC (A) must determine whether or not adding all of the cases listed on the IRF Arthritis Verification Report for that IRF would be enough to increase the IRF's compliance percentage to equal or exceed 60 percent.

3. If adding all of the cases listed on the IRF Arthritis Verification Report for that IRF would be enough to increase the IRF's compliance percentage to equal or exceed 60 percent, then the A/B MAC (A) must use generally accepted statistical sampling techniques to obtain a statistically valid random sample of those patients listed for the IRF on the IRF Arthritis Verification Report. If the total number of patients listed for the IRF on the IRF Arthritis Verification Report is less than 10, then the A/B MAC (A) will review all patients listed for the IRF on the IRF Arthritis Verification Report. (Note that if adding all the cases listed in the IRF Arthritis Verification Report for that IRF would not be enough to increase the IRF's compliance percentage to equal or exceed 60 percent, then the A/B MAC
(A) will not proceed further with the IRF arthritis verification process and will use the presumptive compliance percentage generated from section C above.)

4. The A/B MAC (A) will obtain and examine the medical record sections and any other pertinent information submitted by the IRF to determine if the patients from the random sample obtained in step 2 meet all of the severity and prior treatment requirements specified in §140.1.1B-D.

5. The percentage of patients from the list that the A/B MAC (A) determines to have met the severity and prior treatment requirements specified in §140.1.1B-D will be extrapolated to the complete list of patients for the IRF on the IRF Arthritis Verification Report.

6. The A/B MAC (A) shall then add the appropriate number of cases (based on the percentage in step 4) from the IRF Arthritis Verification Report to the cases that

meet the presumptive compliance criteria, and re-calculate the IRF's presumptive compliance percentage.

For example:

- IRF A submitted 545 IRF-PAIs in the compliance review period.

- IRF A's presumptive compliance percentage (determined by the A/B MAC
(A) using the steps outlined in subsection C above) was less than 60 percent.

- In this case, the A/B MAC (A) must access the IRF Arthritis Verification Report.

- The IRF Arthritis Verification Report shows 100 patients listed for IRF A.

- The A/B MAC (A) determines that inclusion of all 100 patients listed for IRF A would increase IRF A's presumptive compliance percentage enough to meet or exceed the 60 percent threshold.

- The A/B MAC (A) uses generally accepted statistical sampling techniques to randomly select 10 patients from that list for medical review, and based on the medical review determines that 7 of the 10 patients meet all of the requirements specified in §140.1.1B-D.

- The A/B MAC (A) will then extrapolate this percentage (7/10 = 70 percent) to the full list of patients shown on the IRF Eligibility Arthritis Verification Report for IRF A. Thus, the A/B MAC (A) will add 70 patients (70 percent of 100) listed for IRF A on the IRF Arthritis Verification Report to the total number of IRF A's patients that meet the presumptive compliance criteria.

- The A/B MAC (A) will then recalculate IRF A's presumptive compliance percentage with the addition of the 70 cases.

- The A/B MAC (A) will base the determination of the IRF's presumptive compliance with the requirements specified in §140.1.1B-D on the updated calculation of the IRF's presumptive compliance percentage.

- The A/B/ MAC (A) will report this updated presumptive compliance percentage, instead of the presumptive compliance percentage from subsection C above, on the quarterly report that the A/B MAC (A) sends to the appropriate CMS RO (with a copy to the CMS Central Office).

NOTE: Even when an IRF is presumed to have met the requirements specified above in§140.1.1B-D using the updated presumptive methodology calculation, the RO and A/BMAC (A) still have the discretion to use the medical review methodology described in subsection E below to verify the IRF's compliance with the requirements in §140.1.1B-D.

E. - Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility's Total Inpatient Population (Medical Review Methodology)

1. The A/B MAC (A) must use the IRF's total inpatient population to verify that the IRF has met the requirements specified above in §140.1.1B-D if:

(i) the IRF's Medicare population (including Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients, effective October 1, 2009) is not at least 50 percent of its total inpatient population; or

(ii) the A/B MAC (A) is unable to generate a valid IRF compliance review report using the IRF-PAI database methodology specified previously; or
(iii) the A/B MAC (A) generates an IRF compliance review report, based on the use of the presumptive methodology, which demonstrates that the IRF has not met the requirements specified above in §140.1.1B-D.

If the IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) comprise less than 50 percent of the IRF's total inpatient population, or the A/B MAC (A) otherwise determines that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) are not representative of the overall IRF inpatient population, or the A/B MAC (A) is unable to generate a valid report using the presumptive methodology, the presumptive determination is that the IRF did not meet the requirements specified above in §140.1.1B-D.

2. As previously stated above, the A/B MAC (A) will instruct the IRF to send the A/B MAC (A) a list showing the hospital patient number of each inpatient that the IRF admitted during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. The list of hospital patient numbers must include the payer(s) and admission and discharge dates that correspond with the inpatients whose hospital patient numbers are shown on the list. The A/B MAC (A) will then use generally accepted statistical sampling techniques to obtain a random sample of inpatients from the list. The random sample of inpatients drawn from the list must be sufficiently large to ensure that the A/B MAC (A) can determine, with at least 95 percent confidence, whether the IRF's compliance percentage is below the required compliance threshold (i.e., not in compliance) or at or above the required compliance threshold (i.e., in compliance).

For example, suppose that the required compliance threshold for an IRF to be in compliance with the requirements specified above in §140.1.1B-D is 60 percent. The A/B MAC (A) reviews a random sample of claims from IRF A and estimates that IRF A's compliance percentage is 58 percent. Suppose that the standard deviation that the A/B MAC (A) calculates for IRF A's random sample of IRF claims is plus or minus 4 percentage points, so that the 95 percent confidence interval in this particular example is between 54 percent and 62 percent (with 58 percent as the midpoint). In this case, the IRF is considered to be in compliance with the 60 percent rule, since 60 percent is within the 95 percent confidence interval. To verify whether the IRF is in fact in compliance with the requirements specified above in §140.1.1B-D, the A/B MAC (A) may need to draw a larger random sample of the IRF's inpatients. For example, a larger random sample of IRF A's inpatients might have reduced the standard deviation to plus or minus 1 percentage point, which would have led the 95 percent confidence interval to be between 57 percent and 59 percent. This would have demonstrated with 95 percent confidence that the IRF was not in compliance with the requirements specified above in §140.1.1B-D (because the entire 95 percent confidence interval was below the required compliance threshold of 60 percent).

If the compliance percentage threshold differs within the compliance review period (i.e., is 50 percent for a portion of the compliance review period and 60 percent for the other portion of the period), then a random sample of inpatients will be drawn from each of the two time periods separately.

The use of generally recognized statistical sampling principles may result in a determination that it would be inappropriate to use a sample to determine the facility's compliance percentage. If a random sample is not appropriate in a particular case, then the A/B MAC (A) will use the IRF's entire inpatient population to determine the IRF's compliance percentage. In addition, if the IRF had 100 or fewer inpatients during the compliance review period, then the A/B MAC (A) must use the IRF's total inpatient population (consisting of both Medicare and non- Medicare inpatients) to determine the IRF's compliance percentage.

Prior to selecting the random sample of inpatients, the A/B MAC (A) must allow the IRF to decide if the IRF wants the sample to contain either the patients who were admitted during the IRF's compliance review period (even if some of those patients were discharged outside of the compliance review period) or the patients discharged during the IRF's compliance review period (even if some of those patients were admitted outside of the compliance review period).

If the A/B MAC (A) uses a random sample of the IRF's inpatient population (rather than the IRF's total inpatient population) to determine the IRF's compliance percentage, then the A/B MAC (A) must ensure that an adequate sample size is used to determine (with at least a 95 percent statistical level of confidence) whether or not the IRF has met the requirements in §140.1.1B-D. In some cases, this will require the A/B MAC (A) to expand the size of the random sample of inpatients selected from a particular IRF.

The A/B MAC (A) will instruct the IRF to send it copies of specific sections of the medical records for all of the inpatients to be used in the compliance review. The A/B MAC (A) has the discretion to decide which specific sections of the medical recordsto obtain, provided that the requested medical record sections contain enough information to allow the A/B MAC (A)'s reviewers to determine the medical condition(s) for which each inpatient received treatment in the IRF. In addition to submitting the requested sections of the medical records, the IRF has the discretion to send the A/B MAC (A) other clinical information regarding these same inpatients.

3. The A/B MAC (A) will examine the medical record sections and any other information submitted by the IRF to determine if the IRF meets the requirements specified above in §140.1.1B-D. To determine if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the A/B MAC (A) may use the diagnosis and impairment group codes specified in the appropriate files listed in

"Presumptive Methodology Files – Implementation of Changes" that is attached to the IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html, for general guidance. The A/B MAC (A) is not permitted to use these codes to make a final determination as to whether or not the specific inpatient required intensive rehabilitation services for treatment of one or more of the medical conditions specified in §140.1.1C. The determination of whether a specific inpatient required intensive rehabilitation services for treatment of a condition can only be determined through careful review of that inpatient's unique clinical characteristics and circumstances, as reflected in the inpatient's medical record.

4. In general, when the A/B MAC (A) is using a sample of medical records to determine compliance with the requirements in §140.1.1B-D, the A/B MAC (A) always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the results of the presumptive methodology described previously. In other words, the compliance percentage that is determined using the medical review methodology described in this section will supersede the compliance percentage that was determined for the same compliance review period using the presumptive methodology. To ensure that the compliance review process is similar for all IRFs, the A/B MAC (A) must have written policies that describe the reasons for using a random sample of medical records to determine an IRF's compliance percentage when the presumptive methodology has shown that the IRF met the compliance threshold.

5. The A/B MAC (A) will inform the RO if an IRF fails to provide information in accordance with the requirements specified above in subsection D2. The RO will notify the IRF that failure to provide the A/B MAC (A) with the information in accordance with the requirements specified above in subsection D2 will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D.

F. - By the 15th day of each month, the A/B MAC (A) responsible for determining the compliance percentage for each IRF using either of the methods specified above in §§140.1.3C or 140.1.3D will submit a report to CMS via e-mail. Instructions

regarding the format of the report, how to complete the report, and where to send it are specified on the IRF PPS website at: http://www.cms.gov/Medicare/Medicare- Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html .

G. - The A/B MAC (A) must verify that the requirements specified above in

§140.1.1B-E and §140.1.2 G-K were met.

H. - The State Agency will determine whether the criteria specified above in §140.1.1F-K and §140.1.2 Q were met.

140.1.4 - New IRFs

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

A new IRF must provide written certification that the inpatient population it intends to serve will meet the requirements in §140.1.1B-D above. The written certification is effective for the first full 12-month cost reporting period that occurs after the IRF begins being paid under the IRF PPS, and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the IRF begins being paid under the IRF PPS and the start of the IRF's first full 12-month cost reporting period.

As described in section 140.1.9 below, retroactive adjustments may be made for any period during which the hospital has self-attested to meeting the requirements specified in §140.1.1B-D, but is shown not to have actually met these requirements during that period.

140.1.5 - Changes in the Status of an IRF Unit

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

For purposes of payment under the IRF PPS, the status of an IRF unit may be changed from not excluded from the IPPS to excluded from the IPPS only at the start of a cost reporting period. If an IRF unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of the hospital's next cost reporting period.

The status of an IRF unit may be changed from excluded from the IPPS to not excluded from the IPPS at any time during a cost reporting period, but only if the hospital notifies the A/B MAC (A) and the RO in writing of the change at least 30 days before the date of the change. In addition, the hospital must maintain the information needed to accurately determine which costs are and are not attributable to the IRF unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the remainder of that cost reporting period.

140.1.6 - New IRF Beds

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any time during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified.

New IRF beds are included in the compliance review calculations for determining compliance with §140.1.1B-D above from the time that they are added to the IRF.

140.1.7 - Change of Ownership or Leasing

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

If an IRF hospital (or a hospital that has an IRF unit) undergoes a change of ownership or leasing, as defined in 42 CFR §489.18, the IRF hospital (or IRF unit of a hospital) retains its excluded status and will continue to be paid under the IRF PPS before and after the change of ownership or leasing if the new owner(s) of the IRF hospital (or the hospital with an IRF unit) accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be purchased outside of the purchase of its host hospital.

If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to the Medicare program to operate a new IRF, under the requirements for new IRFs in §140.1.4 above.

If, after the change of ownership or leasing, the IRF does not continue to meet all of the requirements for payment under the IRF PPS, then the IRF loses its excluded status and will be paid instead under the IPPS.

140.1.8 - Mergers

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the IRF PPS before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its

host hospital and therefore cannot be merged with another entity outside of the merger with its host hospital.

If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may re-apply to the Medicare program to operate a new IRF under the requirements for new IRFs in §140.1.4 above.

140.1.9 - Retroactive Adjustments for Provisionally Excluded IRFs or IRF Beds

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

For cost reporting periods beginning on or after October 1, 1991, if a new IRF (or new beds that are added to an existing IRF) are paid under the IRF PPS for an initial cost reporting period during which the hospital has self-attested to meeting the requirements specified above in §140.1.1B-D, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period do not meet the requirements specified above in §140.1.1B-D, CMS adjusts payments to the hospital retroactively in accordance with the procedure specified below.

A. - If an IRF hospital, IRF unit, or group of new IRF beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet the requirements specified above in §140.1.1B-D, but does not actually meet the requirement for that cost reporting period, CMS adjusts Medicare payments to the hospital retroactively in accordance with paragraph C below.

B. - In the case of a unit to which new beds have been added, the requirement in §140.1.1B-D above is applied to the entire unit, including both new and existing beds. If the entire unit is able to meet the requirement, the previously existing unit and the added beds are presumed to meet the requirement separately and no payment adjustment as specified below in paragraph C is made. If the unit as a whole does not meet the requirement specified above in §140.1.1B-D, the hospital must furnish the A/B MAC (A) or the State Agency, as specified by the RO, the information needed to determine whether the requirement specified in §140.1.1B-D above was met by the established portion of the unit (that is, the previously existing unit) and by the newly added beds, considered separately. If the hospital is not able to demonstrate that the established portion of the unit met the requirement, then that portion of the facility will not be classified as an IRF for the following cost reporting period. Retroactive adjustments may apply.

If the added beds are shown to have met the requirement specified above in §140.1.1B-D, then those beds are eligible to be included as part of the unit's classification as an IRF for the following cost reporting period. If the added beds did not meet the requirement, the A/B MAC (A) adjusts its payment to the unit retroactively in accordance with paragraph C below and the added beds will not be included as part of the unit classified as an IRF for the following cost reporting period.

If the hospital does not have the records needed to discriminate between the performance of the previously existing unit and that of the added beds, or for other reasons does not furnish the information requested by the A/B MAC (A) or State Agency, neither the previously existing unit nor the added beds will be classified as an IRF for the following cost reporting period. In that case, the A/B MAC (A) adjusts its payment to the entire unit retroactively in accordance with paragraph C below.

C. - The A/B MAC (A) adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the IRF hospital, IRF unit, or new IRF beds during the period of provisional exclusion, and the amount that would have been paid if the IRF hospital, IRF unit, or new IRF beds had not been excluded from the IPPS. The A/B MAC (A) then takes action to recover the resulting overpayment, or corrects the underpayment to the hospital.

140.2 - Payment Provisions Under IRF PPS

(Rev.10321, Issued: 08-28-2020, Effective: 10-01-2020, Implementation: 10-05-2020)

Section 1886 of the BBA provides the basis for establishing the Federal payment rates applied under PPS to IRFs. The PPS incorporates per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system.
IRF PPS providers are not subject to the 3-day payment window for pre-admission services, but are subject to the 1-day payment window for pre-admission services.

Beneficiary liability will operate the same as under the current Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system. Even if Medicare payments are below cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

Below are the annual rate update Change Requests (CRs) for the applicable

Fiscal Years (FYs):

FY 2021 – CR 11858
FY 2020 – CR 11345
FY 2019 – CR 10826
FY 2018 – CR 10125
FY 2017 – CR 9669
FY 2016 – CR 9236
FY 2015 – CR 8788
FY 2014 – CR 8326
FY 2013 – CR 7901
FY 2012 – CR 7510
FY 2011 – CR 7076
FY 2010 – CR 7029
FY 2010 – CR 6607

FY 2009 – CR 6166
FY 2008 – CR 5694
FY 2007 – CR 5273
FY 2006 – CR 4037
FY 2005 – CR 3378
FY 2004 – CR 2894
FY 2003 – CR 2250

Change Requests can be accessed through the following CMS Transmittals Website:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html

140.2.1 - Phase-In Implementation

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Under the BBA, the Federal fiscal year in which a facility's cost reporting period begins determines which transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during Federal fiscal year 2001. The second transition period percentages are applicable to cost reporting periods beginning during Federal fiscal year 2002, that is, periods beginning on or after October 1, 2001, and before October 1, 2002. For cost reporting periods beginning during Federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted Federal prospective payment.

Since CMS is implementing the IRF PPS for discharges that occur during the IRF's cost reporting period that begins on or after January 1, 2002, IRFs are phased directly into the second transition period, where payment will be based on 66 2/3 percent of the PPS payment and 33 1/3 percent of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to January 1, 2002.

In addition, §305 of the BIPA 2000 states facilities may elect to be paid 100 percent PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their A/B MAC (A) no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the Medicare A/B MAC (A) for the facility. The A/B MAC (A) must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

140.2.2 - Payment Adjustment Factors and Rates

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j) of the Act sets forth the methodology for establishing the payment rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and other factors the Secretary deems necessary to ensure that payment most accurately reflects cost.

For the initial period of the IRF PPS, beginning on or after January 1, 2002, all payment rates and associated rules were published in the "Federal Register" on August 7, 2001. For each succeeding fiscal year, the rates will be published in the "Federal Register" on or before August 1 of the year preceding the affected fiscal year.

140.2.3 - Case-Mix Groups

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities were used to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. In addition to the first two digits of the CMG indicating the RIC, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age improves the explanatory power of the CMGs if some groups are split based on this variable. Lastly, comorbidites were found to substantially increase the average cost of a case in specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

140.2.4 - Case-Level Adjustments

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Payment is based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. For case level adjustments, more than one case level adjustment may apply to the same case. For ease of understanding, the case level discussion is presented below in the same order that is used to assess whether or not they apply. For example, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for interrupted stay cases and the payment will be based on the initial assessment. For example, if a Medicare beneficiary is discharged on February

1, 2001, and is readmitted on February 3, the case would be considered an interrupted stay and only one CMG payment will be made based on the initial assessment. However, if the Medicare beneficiary was readmitted on February 4, then it would not be considered an interrupted stay. A separate DRG payment will not be made to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, a DRG payment can be made if the beneficiary does not return to the same IRF on the same day as they were discharged. If a case is determined to be an interrupted stay, other adjustments may apply to this payment amount. For example, the case still may meet the definition of a transfer case described below.

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Cases that expire with a length of stay of 3 days or less, will also be classified to CMG 5001.

Separate CMGs will also be made for cases that expire with a length of stay greater than 3 days. To improve the explanatory power of the groups, four additional CMGs were created to account for cases that expire. CMG 5101 is used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09 and the length of the stay is greater than 3 days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

140.2.5 - Facility-Level Adjustments

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facilities located in rural areas, an adjustment for treating low-income

patients and an adjustment for teaching facilities. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can be determined to qualify for these additional payments only after all other facility-level adjustments are computed. Thus, for ease of understanding, the discussion of these facility-level and outlier adjustments are presented in the same order that is used to assess their applicability.

140.2.5.1 - Area Wage Adjustments

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

To adjust payments for area wage differences, CMS first identifies the labor-related portion of the prospective payment rates which is published annually in the **Federal Register**. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. CMS uses the inpatient acute care hospital wage data to compute the wage indices on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under §§1886(d)(8) or (d)(10) of the Act and without applying the "rural floor" under §4410 of the BBA. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare part B, because these services are not covered under the IRF PPS. For IRF PPS discharges occurring before October 1, 2005, IRFs are divided into labor market areas where urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget.

For IRF PPS discharges occurring on or after October 1, 2005, the IRF PPS adopts new labor market area definitions based upon the new statistical area definitions issued by the Office of Management and Budget (OMB) in OMB Bulletin No. 03-04, June 6, 2003. OMB Bulletin No. 03-04 includes new definitions of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, more commonly referred to as Core-Based Statistical Areas (CBSAs). CBSA-based designations reflect the most recent available geographic classifications and more accurately reflect current labor markets. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs. CMS uses the county-based areas for <u>all</u> MSAs in the Nation, including those in New England. Adopting county-based labor market areas for the entire country creates consistency and stability in the Medicare payment program because all of the labor market areas, including New England, are defined using the same system (that is, counties), rather than different systems in different areas of the country, and minimizes program complexity. CMS uses the Metropolitan Divisions where applicable under the new CBSA-based labor market area definitions to determine urban areas. Micropolitan Areas are treated as rural labor market areas under the IRF PPS. To calculate the statewide rural wage index for each State, CMS combines all of the counties in a State outside of designated urban areas along with all Micropolitan Areas. The wage indices applicable to IRF PPS discharges occurring on or after October 1, 2005 are published annually in the Federal Register.

140.2.5.2 - Rural Adjustment

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-urban area.

For FY 2006 and FY 2007, a hold harmless policy applies to IRFs that meet the definition of rural in FY 2005 in §412.602 and become urban under the FY 2006 CBSA-based designations. The IRFs that meet the criteria described in the previous sentence will qualify for an adjustment to their payments in FY 2006 and FY 2007 equal to some portion of the 19.14 percent rural adjustment effective in FY 2005. This adjustment is in addition to the one-year blended wage index described above for discharges occurring on or after October 1, 2005 and on or before September 30, 2006.

140.2.5.3 - Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate, a file will be updated annually (usually each October/November).

Patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111), which includes both Condition Code 04 and the CMG code from the IRF PAI, to their Medicare contractor. This will ensure that these days are included in the IRF’s SSI ratio for Fiscal Year 2007 and beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

IRFs that received LIP payments during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

Informational Only Claim Elements:

- Covered 111 TOB
- Condition Code 04
- Medicare Fee-for-Service is the primary payer
- There is no MSP
- Beneficiary's Medicare HICN
- For claims prior to October 1, 2011, report the Revenue Code 0024 line containing CMG A9999 and, instead of inputting the transmission date of the IRF-PAI in the service date field (as is required for FFS claims), input the discharge date as a default for these informational only claims. The discharge date is required on informational only claims to reduce reporting burden for IRFs who may be submitting "old" informational only claims.

NOTE: Effective January 1, 2011, do not report the service date for the revenue code 0024 line. Instead, use occurrence code 50 in place of the service date to report the default discharge date for informational only claims**.**

- Effective October 1, 2011, report the Revenue Code 0024 line containing the CMG from the IRF-PAI and the transmission date of the IRF-PAI in the occurrence code 50 and date field (as is required for FFS claims).

- All other required claim elements

The SSI/Medicare beneficiary data for IRF PPS is available to A/B MACs (A) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. A/B MACs (A) will use this information to update their provider specific file. The files are located at the following CMS Web site address: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html. Select Inpatient Rehabilitation Facility PPS, then select, from the list at the left, SSI Data.

A/B MACs (A) use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. A/B MACs (A) make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the A/B MAC (A) settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The A/B MAC (A) uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation) is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved

under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, CMS recognizes the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the A/B MAC (A) must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the

number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes
Type of Day	Description	Eligible Title XIX Day
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under	No.

140.2.5.4 - Teaching Status Adjustment

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

The teaching status adjustment is a facility level adjustment made to the Federal per discharge base rate to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education. The adjustment is made on a claim basis as an interim payment, with final payment in full for the cost reporting period made through the cost report. Any difference between the interim payments and the actual teaching status adjustment amount computed in the cost report are adjusted through lump sum payments/recoupments when the cost report is filed and later settled. The adjustment is based on the IRF's "teaching variable," which is the ratio of the

number of FTE residents training in the IRF (subject to the FTE resident cap described below) to the IRF's average daily census (ADC).

140.2.5.4.1 - FTE Resident Cap

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, not the number of residents teaching institutions can hire or train. The FTE resident cap is identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. The cap is the number of FTE residents that trained in the IRF during a "base year."

An IRF's FTE resident cap is determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. IRFs that first began training residents after November 15, 2004 will initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

For other types of Medicare providers (including long-term care hospitals) that have been training residents and are currently converting to IRFs, the fiscal intermediary will determine an FTE resident cap for purposes of the IRF teaching status adjustment, applicable beginning with the new IRF's payments under the IRF PPS based on the FTE count of residents during the predecessor facility's most recent cost reporting period ending on or before November 15, 2004. If the predecessor facility did not begin training residents until after November 15, 2004, the facility would initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)), may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

Once established, the FTE resident cap for the teaching status adjustment for the new IRF will be subject to the same rules and adjustments as any IRF's FTE resident cap. CMS will monitor this policy closely to ensure that it is not being inappropriately manipulated.

IRFs are not permitted to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents floating through the rehabilitation hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IRF (for example, a resident on a full-time, 3-month rotation to the IRF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS IME adjustment is allowed to be counted for purposes of the teaching status adjustment for the IRF PPS.

The denominator used to calculate the teaching status adjustment under the IRF PPS is the IRF's average daily census (ADC) from the current cost reporting period. If a rehabilitation hospital or unit has more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If a rehabilitation hospital or unit were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility hires and trains).

Effective for cost reporting periods beginning on or after October 1, 2011, the IRF FTE resident caps may be temporarily adjusted to reflect interns and residents added because of another IRF's closure or the closure of another IRF's residency training program. An IRF is only eligible for the temporary cap adjustment if training the additional interns and residents would cause the IRF to exceed its FTE resident cap. In addition, an IRF that closes a medical residency training program must agree to temporarily reduce its FTE cap before other IRFs can receive temporary adjustments to their caps for training the IRF's interns and residents. IRFs may qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011 if they are already training interns and residents displaced by IRF closures or residency training program closures that occurred prior to October 1, 2011.

140.2.5.5 - Outliers

(Rev. 2673, Issued: 03-14-13, Effective: 04-22-13, Implementation: 04-22-13)

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. CMS calculates the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, CMS calculates the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the Federal Register.

140.2.6 - Cost-to-Charge Ratios

(Rev. 2323, Issued: 10-26-11, Effective: 11-28-11, Implementation: 11-28-11)

For discharges beginning on and after January 1, 2002 thru September 30, 2003, the Medicare contractor shall use the instructions for calculating the CCR for purposes of determining outlier payments under the IRF PPS set forth in Transmittal A-01-131.

For discharges beginning on or after October 1, 2003, the Medicare contractor shall use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period), specific to freestanding IRFs or for IRFs that are distinct part units of acute care hospitals in accordance with the formulas set forth below.

Effective October 1, 2003, if an IRF's CCR is above the applicable ceiling set forth annually in the IRF PPS notices published in the **Federal Register** it is considered to be statistically inaccurate. As a result, CMS will assign the IRF an appropriate national average CCR. CMS does not use a lower threshold; an IRF will receive their actual CCR, no matter how low their ratio falls.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of the inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swingbed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file (PSF) contains a field for the operating CCR (Field 25; file position 102-105) and for the capital CCR (Field 42; file position 203-206). Because the CCR computed for the IRF PPS includes routine, ancillary, and capital costs, the CCR for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

The Medicare contractor shall continue to update the IRF's CCR each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the PSF not later than 30 days after the date of the latest settlement used in calculating the CCR.

A. - Calculating Medicare CCRs for Freestanding IRFs

1) Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges), from Worksheet D-4, Column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

B. - Calculating Medicare CCRs for IRF Distinct Part Units

1) Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IRF unit that has the letter "T" or “R” in the third position of the Medicare provider number.

C. - Calculating Medicare CCRs for New IRFs

In the case of a New IRF unit (defined in 42 C.F.R. 412.30) or a New Inpatient Rehabilitation Hospital (defined as a hospital that has never entered into a provider agreement with the Secretary), the Medicare contractor shall use a national average CCR based on the facility location of either urban or rural. The national average CCRs applicable to IRFs shall be found in each year’s annual notice of prospective payment rates published in the Federal Register.

The national average CCR will be used until the IRF’s actual CCR can be computed using the first tentative settled or final settled cost report data, which will then be used for the subsequent cost report periods.

We NOTE, the policies in §§ E and F below can be applied as an alternative to the national average CCR.

For those IRFs assigned the national average CCR, the CCR must be updated every October 1 based on the latest national average CCRs published in each year’s IRF PPS annual notice of prospective payment rates until the IRF is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D. - Mergers, Conversion and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IRF with the surviving provider number. If a new provider number is issued (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement), the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

When errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek guidance. Likewise, when a cost report is reopened after final settlement and as a result of this reopening there is a change

to the CCR; Medicare contractors should contact the CMS Central Office for further instructions.

E. - Alternative CCRs

The CMS may direct the Medicare contractor to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentative settled cost report, if it believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor should contact the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in an IRF's operations occurs which materially affects the IRF's costs and/or charges. Notification to the CMS Central Office shall be sent to the mailing address or email address provided in Part (f) below. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the Medicare contractor for use of an alternative CCR. Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

F. - Request for Use of a Different CCR by the IRF

Also, an IRF will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IRF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the IRF, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of such a request. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the IRF for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office at the following address or email address:

CMS
C/O Division of Institutional Post Acute Care
7500 Security Blvd
Mail Stop C5-06-27
Baltimore, MD 21244

irf_outlier_reconciliation@cms.hhs.gov

Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

G. - Notification to Facilities Under the IRF PPS

The Medicare contractor shall notify an IRF whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the

change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.

H. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When recalculating claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the PSF. This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: 21 -Case Mix Adjusted Cost Per Discharge, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio, -28 -Medicaid Ratio and 49 -Capital IME. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

140.2.7 - Use of a National Average Cost-to-Charge Ratio

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A national average CCR based on the facility location of either rural or urban is applied in the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.
- IRFs whose overall CCR is in excess of the national CCR ceiling, as set forth annually in the IRF PPS notices published in the **Federal Register**.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

However, the policies of §140.2.6 part E and F can be applied as an alternative to the national average CCR.

The national urban and rural CCRs for IRFs are set forth annually in the **Federal Register**.

140.2.8 - Reconciling Outlier Payments for IRFs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. - General

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, Medicare contractors are to reconcile IRF PPS outlier payments at the time of cost report final settlement if:

1) Actual CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2) Outlier payments exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which outlier payments were made in a cost reporting period.

In the event that these criteria do not identify facilities that are being overpaid (or underpaid) significantly for outliers, then, based on an analysis of the facility's most recent cost and charge data that indicates that the CCR for those facilities are significantly inaccurate, Medicare contractors and the CMS Central Office also have the administrative discretion to reconcile cost reports of those IRFs. However, Medicare contractors must seek approval from the CMS Regional Office and CMS Central Office in the event they intend to reconcile outlier payments for an IRF that does not meet the above-specified criteria.

To determine if an IRF meets the criteria for outlier reconciliation, the Medicare contractor shall perform the following steps: (1) incorporate all the adjustments from the cost report, (2) run the cost report, (3) calculate the revised CCR and (4) compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria are not met, the cost report can be finalized. If the criteria are met, Medicare contractors shall follow the instructions in §140.2.10. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect IRF PPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Central and Regional Offices for further instructions. Notification to the CMS Central Office shall be sent to the mailing address or email address provided in §140.2.6(F) above.

The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE A:

Cost Reporting Period: 01/01/2010-12/31/2010

CCR used to pay original claims submitted during cost reporting period: 0.40

(In this example, this CCR is from the tentatively or final settled 2007 cost report)

Final settled CCR from 01/01/2010-12/31/2010 cost report: 0.50

Total IRF PPS outlier payout in 01/01/2010-12/31/2010 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in IRF PPS outlier payments during that cost reporting period, the criteria are met for reconciliation, and therefore, the Medicare contractor notifies the CMS Central Office and the Regional Office. The provider's IRF PPS outlier payments for this cost reporting period are reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period to calculate outlier payments, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. Example B below shows how to weight the CCRs. The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if IRF PPS outlier reconciliation is required. Total IRF PPS outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE B:

Cost reporting period: 01/01/2010-12/31/2010

CCR used to pay original claims submitted during cost reporting period:
0.40 from 01/01/2010 to 03/31/2010 (This CCR could be from the tentatively settled 2006 cost report.)

0.50 from 04/01/2010 to 12/31/2010 (This CCR could be from the tentatively settled 2007 cost report.)

Final settled CCR from 01/01/2010 - 12/31/2010 cost report: 0.35

Total IRF outlier payout in 01/01/2010 -12/31/2010 cost reporting period: $600,000

Weighted average CCR: 0.476

CCR	**DAYS**	**Weight**	**Weighted CCR**
0.40	90	0.247 (90 Days / 365 Days)	(a) 0.099 = (0.40 * 0.247)
0.50	275	0.753 (275 Days / 365 Days)	(b) 0.377 = (0.50 * 0.753)
TOTAL	365	365	(a)+(b) = 0.476

The IRF meets the criteria for IRF PPS outlier reconciliation in this cost reporting period because the variance from the weighted average CCR at the time the claim was originally paid compared to the CCR from the cost report at the time of settlement is greater than 10 percentage points (from 0.476 to 0.35) and the provider received total IRF outlier payments greater than $500,000 for the entire cost reporting period.

B. - Providers Already Flagged for Outlier Reconciliation

Medicare contractors shall have until April 25, 2011 to submit via email to irf_outlier_reconciliation@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total outlier payments in the cost reporting period, the CCR or weighted CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals that have been flagged for outlier reconciliation. Upon approval from the CMS Central Office, Medicare contractors shall follow the procedures in §140.2.10 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011, shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.

140.2.9 - Time Value of Money

(Rev. 2242, Issued: 06-17-11, Effective: 07-01-11, Implementation: 07-01-11)

Effective for discharges occurring on or after September 30, 2003, at the time of any reconciliation under §140.2.9.10, outlier payment may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the IRF's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If the IRF's outlier payments have met the criteria for reconciliation, the Medicare contractor shall follow the process in §140.2.10. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula will be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation. NOTE: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the Medicare

contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

EXAMPLE C:

Cost Reporting Period: 01/01/2004-12/31/2004
Midpoint of Cost Reporting Period: 07/01/2004
Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional and Central Office.

The Medicare contractor reprocesses and reconciles the claims. The reprocessing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money:
(4.625 / 365) * 549 = 6.9565%

Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.

140.2.10 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IRF is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the IRF), via the street address or email address provided in §140.2.6 (F), and to the

Regional Office that an IRF has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the IRF and copy the CMS Regional Office and Central Office in writing or via email (through the addresses provided in §140.2.6 (F)) that the IRF's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

    a. ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

7) Type of Bill (TOB) equals 11X
8) Previous claim is in a paid status (P location) within FISS
9) Cancel date is 'blank'

10) The Medicare contractor reconciles the claims through the IRF Pricer software and not through any editing or grouping software.

11) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

12) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

13) For facilities paid under the IRF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §140.2.8. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount, then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount, then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

15) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.05, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines, see §3633.1 of the Provider Reimbursement Manual, Part II.

    a. For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part III, line 4, the outlier reconciliation adjustment amount (the difference between the original outlier amount

(value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part III of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 30 of Worksheet E-3, Part 3.

16) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

17) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCR(s) used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IRF PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 - Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the mailing address or email address provided in §140.2.6 (F) with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)

List of Data Elements for FISS Extract
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; ‘Y’ = MSP, ‘blank’ = no MSP
Reason Code

List of Data Elements for FISS Extract
HMO-IME Indicator
Filler

140.2.11 - Quality Reporting Program

(Rev. 3039, Issued: 08-22-14, Effective: 10-01-14, Implementation: 10-06-14)

Section 1886 (j)(7)(A)(i) of the Act requires application of a 2% reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2014 is to be the first year that the mandated reduction will be applied for IRFs that failed to comply with the data submission requirements during the data collection period October 1, 2012 through December 31, 2012. Thus, in compliance with 1886(j)(7)(A)(i) of the Act, we will apply a 2 percentage point reduction to the applicable FY 2014 market basket increase factor in calculating an adjusted FY 2014 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2% reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2014 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from October 1, 2012 through December 2012 will be $14,555.

After the reconsideration process has occurred and prior to October 1 of each FY, CMS will provide the Medicare contractors with a final list of IRFs that failed to comply with the data submission requirements. The Medicare contractors will then be responsible for notifying each IRF that failed to comply with the quality data submission requirements that it will receive a 2% reduction in payment. Additionally, the Medicare contractors shall include information regarding the IRFs right to further appeal the 2% reduction via the Provider Reimbursement Review Board (PRRB) appeals process. Contractors shall send this second letter only to IRFs that requested a reconsideration. Medicare contractors shall include the model language at the end of this section in their notification letter to the IRFs.

The Medicare contractor shall update (or not update) the IRF's provider file based on the appropriate scenario listed below:

- If the IRF was notified that it was potentially subject to the 2% reduction, and did not request a reconsideration, then the Medicare contractor shall set a quality reporting indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all of the IRF's claims for the upcoming fiscal year.

- If the IRF was notified that it was potentially subject to the 2% reduction, and requested a reconsideration, but on reconsideration CMS upheld the decision to apply the 2% reduction, then the Medicare contractor shall set a quality reporting indicator in the provider file that triggers Medicare systems to calculate the 2% reduction on all of the IRF's claims for the upcoming fiscal year.

- If the IRF was notified that it was potentially subject to the 2% reduction, and requested a reconsideration, and on reconsideration CMS determined that the IRF should not be subject to the 2% reduction (i.e., reversed its decision), then the Medicare contractor shall not update the quality reporting indicator in the IRF's provider file and shall notify the IRF that they will receive their full IRF PPS payment update for the upcoming fiscal year.

- If the IRF submitted the necessary IRF Quality Reporting data and was never notified that it might potentially be subject to the 2% reduction, then the Medicare contractor shall take no action regarding the quality reporting indicator in the IRF's provider file.

Below are the Quality Annual Rate Updates for the applicable Fiscal Years (FYs):

FY	data collection from	data collection through	adjusted standard payment conversion factor
FY 2014	10/01/2012	12/31/2012	$14,555
FY 2015	01/01/2013	12/31/2013	$14,901

140.3 - Billing Requirements Under IRF PPS

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on the ASC X12 837 institutional claim or, in rare cases, on the Form CMS-1450 for all Part A inpatient claims (Type of Bill 11X) to their A/B MACs (A). The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to

accurately price and pay a claim under the IRF PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Discharge Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

- For atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).

Covered Charges should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate

times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- IRFs are required to report the number of units based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the A/B MAC (A) with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should

this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

140.3.1 - Shared Systems and CWF Edits

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

- To insure that revenue code 0024 is not reported more than once on bill type 11X;
- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.
- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);
- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);
- To reject subsequent claims with the same PPS provider on the same day (CWF);
- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date;
    - CWF accepts the incoming claim and sends an informational unsolicited response to the A/B MAC (A) on the history claim if the patient status code does not match the incoming provider number
    - The A/B MAC (A) cancels the history claim to the provider
- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim;
- CWF rejects the incoming claim if the patient status code does not match the provider number;
- A/B MAC (A) returns the incoming claim to the provider for correction of the patient status code.
- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.
- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;
- Units entered on the 0024 must be accepted, but are not required.

- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,

- To insure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay ≤ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/

- The accommodation revenue code 018x (leave of absence) will continue to be used in the current manner including the appropriate occurrence span code 74 and date range.

140.3.2 - IRF PPS Pricer Software

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The CMS has developed an IRF Pricer Program that calculates the Medicare payment rate. Pricer will use a variety of inputs listed below to calculate the payment rate.

A. Inputs to Pricer

- Provider Specific File data (see section 20.2.3.1 and Addendum of this chapter for required elements)

- Bill Data includes:

  - Patient Status:

  - Payment Modification Flag (if condition code is 66, set flag "Y" otherwise use "N.");

  - Covered Charges;

  - Discharge Date;

  - HIPPS/CMG Rate Code;

- Length of Stay (LOS);
- Covered Days;
- Lifetime Reserve Days (LTR)

B. Data Returned From Pricer

Pricer returns the following information:

- PPS Return Code
- MSA /CBSA (effective October 1, 2005)
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-Income Payment (LIP) Amount
- Teaching Amount (effective October 1, 2005)
- LOS
- Regular Days Used
- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend

- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

The Pricer is available electronically to the Shared Systems.

140.3.3 - Remittance Advices
(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

A remittance advice remark code is used to notify an IRF when the CMG code was changed.

The following reflects the remittance advice messages and associated codes that will appear when communicating claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: N/A
CARC: N/A
RARC: Alert N69
MSN: N/A

150 - Long Term Care Hospitals (LTCHs) PPS
(Rev. 1, 10-01-03)
PM A-02-093

150.1 - Background
(Rev. 1, 10-01-03)

LTCHs are certified under Medicare as short-term acutecare hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under §1886(d)(1)(B)(iv) of the Act and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days. This PPS replaced the previous reasonable cost-based payment system for LTCHs.

150.2 - Statutory Requirements
(Rev. 1, 10-01-03)

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based

on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

The CMS satisfied the statutory implementation requirement by establishing October 1, 2002 as the effective date of the LTCH PPS with systems changes to follow. Payments for LTCH services furnished for cost reporting periods beginning on or after October 1, 2002 are based on the policies set forth in the August 30, 2002 final rule (67 FR 55954).

150.3 - Affected Medicare Providers

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

LTCHs are certified under Medicare as short-term acute care hospitals and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days.

Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1) are not included in the LTCH PPS. (See 42 CFR §412.22(c).) Payment to foreign hospitals will be made in accordance with the provisions set forth in 42 CFR 413.74. Currently, two of the four Maryland LTCHs included on CMS' OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center and Deaton Hospital and Medical Center (now known as University Specialty Hospital).

150.4 - Revision of the Qualification Criterion for LTCHs

(Rev. 208, 06-18-04)

Under the LTCH PPS, the greater than 25-day average length of stay (ALOS) calculation is based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days. For cost reporting periods beginning on or after October 1, 2002, LTCHs are required to meet this revised criteria in order to qualify as LTCHs for Medicare payment purposes.

The average Medicare length of stay is calculated by dividing the total number of covered and noncovered days of care provided to Medicare patients, by the Medicare discharges occurring during that period. If the days of a stay involve days of care furnished during two or more separate cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future cost reporting period, the total number of days of the stay are considered to have occurred during the cost reporting period during which the patient was discharged. For cost reporting periods beginning on or after July 1, 2004, if a hospital fails to meet the ALOS requirement under this provision, the A/B MAC (A) will determine the ALOS for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2005 by dividing the applicable total days for Medicare inpatients

during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period.

If the A/B MAC (A) determines that the LTCH does not qualify, A/B MACs (A) are to follow the procedures already established in the Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01). The new manual can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html?redirect=/manuals/cmsindex.asp. Select Internet-Only Manuals (IOM) from the left side of the page, then select 100-01.
The CMS requires on-going monitoring of LTCH compliance with the above requirements as well as notification by A/B MACs (A) regarding this compliance.

150.5 - Payment Provisions Under LTCH PPS
(Rev. 1, 10-01-03)

Section 123 of Public Law 106-113(BBRA), as amended by §307 of Public Law 106-554(BIPA), authorizes the establishment of Federal payment rates under PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, to ensure that payment most accurately reflects cost.

The CMS has established a transition to full payments under the LTCH PPS: a 5-year phase-in during which a decreasing percentage of payments will based upon what payments would have been under the reasonable cost-based system. LTCHs may also elect to receive payment based on 100 percent of the "Federal payment rate." New LTCHs are to be paid based fully on 100 percent of the Federal rate (i.e. hospitals for which the first cost reporting period as an LTCH began on or after October 1, 2002). (See §150.10.1.)

150.5.1 - Budget Neutrality
(Rev. 1, 10-01-03)

The BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.

150.5.2 - Budget Neutrality Offset
(Rev. 3445, Issued: 01-29-16, Effective: 01-01-16, Implementation: 04-04-16)

A reduction factor to all Medicare payments during the transition to account for the monetary effect of the 5-year transition from the present cost-based payment system and the LTCH PPS, and the policy to permit LTCHs to elect payment solely under the PPS rather than based on the blend during the transition. (See §150.10.1.)

If a LTCH is paid under the transition blend methodology, the budget neutrality offset will be applied to both the TEFRA Rate Percentage and the Federal Rate percentage.

The budget neutrality offset equals 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made had the LTCH PPS not been implemented to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on the 100 percent of the Federal rate.

The per discharge Federal rates under the PPS are based on average LTCH costs in a base year updated for inflation to the first effective period of the system.

Fiscal year changes to the LTCH PPS system occur annually in October. Specific instructions will be published shortly after the publication of the LTCH Final Rule each year. In addition, other changes to the inpatient prospective payment system may occur in January, April or July as necessary.

150.6 - Beneficiary Liability
(Rev. 1, 10-01-03)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system, i.e., if Medicare payments are below the cost of care for a patient under prospective payment, the patient cannot be billed for the difference.

As under the former TEFRA cost-based payment system, beneficiaries (or their Medigap insurers or other private insurers, such as an employer-sponsored plan, as applicable) are responsible for all noncovered days, where Medicare has not made a full LTC-DRG payment.

For more detailed information regarding lifetime reserve days, refer to the Medicare Benefit Policy Manual, chapter 5.

150.7 - Patient Classification System
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

The BBRA required the use of diagnostic-related groups (DRGs) for patient classification purposes in the PPS for LTCHs. In general, a case is grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings are called LTC-DRGs, which are based on the existing CMS DRGs used under the acute care hospital inpatient PPS. Patient discharges are grouped using ICD diagnosis codes reported on the claim for the principal diagnosis, up to twenty four additional diagnoses, and up to twenty five procedures performed during the stay, as well as age, sex, and discharge status of the patient.

The same GROUPER software developed by 3M for the acute care hospital inpatient PPS, is used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients).

150.8 - Relative Weights
(Rev. 1, 10-01-03)

Payment weights assigning a specific value representing the relative resource use of each LTC DRG are determined by the hospital-specific relative value method. This methodology normalizes charges within each hospital and then compares them across hospitals. Relative weights are updated annually October 1 using the most recent available claims data. Relative weights and the geometric average length of stay are in the Pricer program.

150.9 - Payment Rate
(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Payments to LTCHs under the LTCH PPS are based on a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors). This single standard Federal rate is updated annually by the excluded hospital with capital market basket index. The formula for an unadjusted LTCH PPS prospective payment is as follows:

- Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate Case-Level Adjustments

Effective July 1, 2003, the annual update to the standard Federal rate is based on the "LTCH PPS rate year" of July 1 through June 30, rather than the Federal fiscal year (October 1 through September 30). July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

150.9.1 - Case-Level Adjustments
(Rev. 1, 10-01-03)

Payments are based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments are applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

150.9.1.1 - Short-Stay Outliers
(Rev. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

- Generally, a short-stay outlier (SSO) is a case that has a covered length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. Effective for LTCH PPS discharges occurring on or before June 30, 2006, the adjusted payment for an SSO case is the least of:

  - 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio (CCR) and covered charges from the bill);

  - 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or

  - The full LTC-DRG payment.

To compute 120% of cost:

- Charges x CCR = Cost ($13,870.33) x (0.8114) = $11,254.39

- 120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

  Full LTC-DRG payment:

  $34,956.15 (FY 2003 standard Federal rate)

  x 0.72885 (labor %)

  $25,477.79 (labor share)

  x 1.0301 (1/5th wage index value for FY 2003)

  $26,244.67 (wage adjusted labor share)

  + 9,478.36 (non-labor share=$34,956 x 0.27115)

  $35,723.03 (adjusted standard Federal rate)

  x 1.4103 (LTC-DRG 113 relative weight)

  $50,380.19 (full LTC-DRG payment

  Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this example, the case is paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 - 34513).

For RY 2007, the SSO policy was revised as follows:

- Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case is equal the least of:
    - 100 percent of estimated cost of the case,
    - 120 percent of the LTC-DRG per diem amount,
    - the full LTC-DRG payment, or
    - a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent LTC-DRG per diem amount is based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment is no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) is applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).

The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC DRG payment is $38,597.41, the LTCH PPS geometric ALOS is 33.6

days, the LTCH PPS SSO threshold (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is $8,019.82, and the IPPS geometric ALOS is 4.5 days.

SSO Example #1 - LOS equals 11 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x11 days x 1.2 33.6 days	$15,163.27
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
1c	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	0.44 x $15,163.28	$6,671.84
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$19,604.00
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($19,604.00)	$8,019.82

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 - 0.44	0.56
2d	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	0.56 x $8,019.82	$4,491.10
3	Compute the blend alternative	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$6,671.84 + $4,491.10	$11,162.94

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

<u>SSO Example #2 - LOS equals 27 Days</u>:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$\frac{\$38,597.41}{33.6 \text{ days}}$ x 27 days x 1.2	$37,218.93

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent	27 days ÷ 25 days is > 1; therefore percent is 1.00	1.00
1c	Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)	1.0 x $37,218.93	$37,218.93
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$48,118.92
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($48,118.92)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 - 1.00	0.00

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
2d	Determine the IPPS comparable per diem amount portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)	0.00 x $8,019.82	$0.00
3	Compute the blend alternative	Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$37,218.93 + $0.00	$37,218.93**

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

** Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.

Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS (i.e., full IPPS comparable amount) includes payment for the costs of inpatient operating services based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, an amount comparable to what would be paid under the IPPS for the case includes a disproportionate share (DSH) adjustment (see §412.106), if applicable, and

includes an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income Ratio (SSI)), and 28 (Medicaid Ratio) are required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to sections 20.3.1.1 and 20.3.1.2 of this manual.

For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) are required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. A LTCH PPS payment amount comparable to what would be paid under the IPPS does not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a)(1) (i.e., if the estimated costs of the case exceeds the adjusted LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.

For RY 2008, the SSO policy was revised as follows:

Effective for LTCH PPS discharges occurring on or after July 1, 2007, and on or before December 28, 2007*, the payment adjustment formula for SSO cases was revised for those cases where the patient's LTCH covered LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payment under the SSO policy is subject to an additional adjustment.

The IPPS-comparable threshold is defined as the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029)).

If the covered LOS at the LTCH is less than or equal to the IPPS-comparable threshold for the LTC-DRG, Medicare payment is based on the IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option replaces the "blend" amount in the adjusted LTCH PPS SSO payment formula.

Effective for discharges occurring on or after July 1, 2007 and on or before December 28, 2007*, therefore, the adjusted Medicare payment for an SSO case where the covered LOS at the LTCH is within the IPPS-comparable threshold, is equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount

The IPPS comparable amount is determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples at 2a.

For SSO cases where the covered length of stay exceeds the "IPPS threshold," payment is made under the SSO payment formula that became effective beginning in RY 2007, as specified above.

***NOTE:** On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Consequently, the fourth option in the SSO payment adjustment formula at §412.529(c)(3)(i) will not apply during this 3-year period, and therefore, there will be no comparison of the covered LOS of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. Therefore, for SSO discharges occurring on or after December 29, 2007, and before December 29, 2012, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007, as described above.

Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)

A "subsection (II)" hospital:

- Was excluded as a LTCH in 1986
- Has an average inpatient LOS of greater than 20 days, and
- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a "subsection (II)" hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., **discharges** occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or120 percent of the per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for **discharges** occurring on or after **July 1, 2003 through the first year of transition 195%**;
- Effective for **discharges** during the second year of the transition, **193%**;
- Effective for **discharges** during the third year of the transition, **165%**;
- Effective for **discharges** during the fourth year of the transition, **136%**; and
- Effective for **discharges** for the last year and thereafter, the percentage returns to **120%**.

150.9.1.2 - Interrupted Stays

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at an LTCH during which the beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the “interruption" would be the responsibility of the LTCH “under arrangements” with one limited exception: for RY 2005 and RY 2006, if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Effective for dates of service on or after July 1, 2006 (RY 2007**)**, this limited exception for surgical DRGs is no longer applicable. No further separate payment to an acute care hospital will be made. Any tests or procedures, that were administered to the patient during that period of time of interruption will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the3-day or less interruption (e.g., the patient is home and doesn’t receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for “under arrangements,” all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

- The original interrupted stay policy is now defined as “a greater than 3-day interruption of stay” and is a stay in which a LTCH patient that is admitted upon discharge to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or swing bed and returns to the same LTCH within a specified period of time. The day count begins on the day of discharge from the LTCH, which is also the admission day to the other provider, and ends on the day of readmission to the LTCH.
    - For an acute care hospital: between 4 and 9 consecutive days;
    - For an IRF: between 4 and 27 consecutive days;
    - For a SNF: between 4 and 45 consecutive days; and
    - For a Swing Bed: between 4 and 45 consecutive days or less.

Note that although the greater than 3-day interruption of stay policy only governs when a patient is away from the LTCH for between 4 days and the applicable provider threshold, the day count for determining whether the threshold is met begins when the patient is discharged. So if a patient is discharged on 9/2/04, the 3-day or less interrupted stay policy will govern payment if the patient is readmitted to the LTCH on 9/2, 9/3, or 9/4. If the patient is readmitted to the LTCH on 9/5, payment will be paid to, for example, the

acute care hospital which provided treatment, but the day count for determining whether or not the stay is one interrupted stay or a whether the return to the LTCH is a separate admission starts on 9/2. For example, if the LTCH discharges a patient to an acute care hospital on 9/2/04, if they are readmitted to the LTCH by 9/10/04, this is an interrupted stay. If they are readmitted on 9/11/04, it counts as a separate admission. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made. (The bill generated by the original stay in the LTCH should be cancelled by the provider or they may do a debit/credit adjustment.)

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

If the length of stay at the "receiving" site of care exceeds the above- specified period of time, the return to the LTCH is a new admission. This means that the original discharge to that site is treated as a discharge for payment purposes.

For the percentage of payments that are to be made under the TEFRA system during the 5-year transition, the A/B MAC (A) treats each segment of the interrupted stay as a separate discharge. (A/B MACs (A) are to follow the same procedure as provided under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

150.9.1.3 - Payments for Special Cases

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Payments for short-stay outliers are determined in the Pricer logic. Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. For example, a case may be a short-stay outlier and also be governed by either the 3-day or less or greater than 3-day interruption of stay policy and therefore only generate 1 LTC-DRG payment to the LTCH.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev. 2060, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

Hospitals within hospitals (HwH), satellite facilities, and onsite SNFs:

The LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, **all** such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)

- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

The LTCHs were required to notify their A/B MACs (A) about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the A/B MACs (A) within 60days of such a change. The implementation of the onsite policy is based on information maintained by A/B MACs (A) on other Medicare providers co-located with LTCHs. A/B MACs (A) notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

Beginning FY 2005, an additional payment adjustment was established for LTCH HwHs and satellites of HwHs relating to the percentage of patients discharged during a specific cost reporting period that were admitted from their host hospital. Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes discharges from "grandfathered" LTCH HwHs and LTCH satellites that were admitted from their host hospitals; LTCH and LTCH satellite discharges from referring hospitals that are not co-located with the discharging facility; and discharges from "free-standing" LTCHs that were admitted from any referring hospital.

Basic Payment Formula under the 25 Percent Threshold Payment Adjustment for Medicare Discharges from Referring Hospitals

NOTE: On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted with mandated several modifications to this policy for a 3-year period beginning on the date of enactment of the Act. For clarity, each modification to the policy is specified in a bullet point immediately below the explanation of the particular aspect of the policy as it was effective on July 1, 2007. The bullet points below also include additional amendments made by the enactment of the American Recovery and Reinvestment Act (ARRA) of 2009 on February 17, 2009, to the 25 percent threshold payment adjustment. It is important to note that for those policies that operate on an October 1 cycle (i.e. pre-MMSEA regulations at 42 CFR §412.534), the ARRA has

amended the MMSEA so that the MMSEA relief is effective for cost reporting periods beginning on or after October 1, 2009, and before October 1, 2010. For policies that operate on a July 1 cycle, (e.g., pre-MMSEA regulations at 42 CFR 412.534(h) and §412. 536) the ARRA amendments to the MMSEA relief are effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.

With the passage of the Affordable Care Act of 2010, all provisions of MMSEA as amended by the ARRA affecting the LTCH PPS were extended an additional 2-years. Therefore, provisions due to sunset on July 1, 2010, and October 1, 2010, have been extended until July 1 2012, and October 1, 2012, respectively. The revisions to this section (below), indicate these new dates.

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**
    - This policy was finalized for FY 2005
    - If a LTCH HwH or satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. For LTCHs and LTCH satellites subject to the transition period described below, there is a 3-year transition to the full 25 percent threshold payment adjustment.

As amended by the MMSEA of 2007 and further amended by the ARRA and the ACA:

- The percentage threshold for "applicable" LTCHs and LTCH satellites (i.e., subject to the transition described below) is raised from 25 percent to 50 percent for LTCH cost reporting periods beginning on or after October1, 2007, and before October 1, 2012. "Grandfathered" LTCH satellites are also "applicable" for this increase, under the ARRA but on a July 1 cycle, as noted above.
- For LTCHs with "special circumstances," specified below, the 50 percent threshold is raised to 75 percent for the same 3-year period.
    - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to Grandfathered LTCH HwHs and LTCH Satellites from their Host Hospitals**

  Prior to the enactment of the MMSEA and the ARRA, this policy was effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition described below, if a grandfathered LTCH HwH or a grandfathered satellite of a LTCH has admitted from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to all LTCHs and LTCH Satellites from Referring Hospitals other than those with which they are Co-located:**

  - This policy is effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition specified below, if a LTCH or LTCH satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. (See details of this payment adjustment below the discussion of the MMSEA and the ARRA changes.)

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As amended by the MMSEA of 2007 and further amended by the ARRA and the ACA:

- For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2012, grandfathered LTCH HwHs are exempted from the 25 percent threshold for admissions from co-located hospitals or referring hospitals with which they are not co-located.

- "Freestanding" LTCHs, i.e., LTCHs not co-located with another hospital as a HwH or as a satellite are exempted from the 25 percent threshold for admissions from any referring hospital.

As amended by the ARRA of 2009:

- The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located.

The 5-year delay in the application of the percentage threshold payment adjustment for each of the above categories is effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2012.

NOTE: For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2012 or on or after October 1, 2007, and before October 1, 2012, as applicable (see explanation above), this payment adjustment continues to be applicable under the specific circumstances set forth in the MMSEA and the ARRA as amended by the ACA.

Payment adjustment under the 25 percent threshold payment policy

Under the LTCH PPS, payments for LTCH or LTCH discharges in excess of the specified threshold percentages are based on the lesser of an amount otherwise payable under the LTCH PPS or an amount that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located and the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, an amount equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment and where applicable, an IME adjustment.

Additionally, to arrive at the payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted by the applicable geographic adjustment factors set forth, including local cost variation (based on the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule), large urban location, and COLA, if applicable.

For discharges governed by this payment, an amount that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment if applicable, and an equivalent IME adjustment), if applicable.

An amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since, under the IPPS, there are separate Medicare rates for operating and capital costs to acute care hospitals, while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospital's services provided to LTCH Medicare patients.

Note that there is a difference between the policy that we have codified for adjusted payments to LTCH HwHs and satellites of LTCHs, which is based on an amount "equivalent" under the existing payment, and the additional component to the SSO payment adjustment that is based on an amount "comparable" to what would otherwise be paid under the IPPS adjustment. The distinction is that if a SSO case also qualifies as a high cost outlier (HCO) case after the SSO payment amount is determined, the SSO payment formula uses the LTCH PPS fixed loss amount. In contrast, under the payment adjustment for LTCH HwHs and LTCH satellites if the amount payable by Medicare for a specific case is <u>equivalent</u> to what would be otherwise payable under the IPPS and the case also qualified as a HCO, the outlier payment for this case would be based on the IPPS HCO policy because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment the lesser amount resulted in an "otherwise payable amount under the LTCH PPS," and the stay qualified as a HCO, Medicare would generate a HCO payment governed by the LTCH PPS fixed loss amount calculated under the LTCH PPS and if the estimated cost of the case exceeds the adjusted LTC-DRG plus a fixed loss amount under §412.525(a), the LTCH would receive an additional payment based on the LTCH PPS HCO policy.

Specific Circumstances (applicable to all of the above scenarios)

> **NOTE:** MMSEA changes described above, as amended by the ARRA and further amended by the ACA, are applicable for cost reporting periods beginning on or after October 1, 2007, and before October 1, 2012, or on or after July 1 2007, and before July 1, 2012..

- For LTCHs and LTCH satellites located in rural areas, instead of the 25 percent threshold, we provide for a 50 percent threshold for patients from any individual referral hospital. In addition, in determining the percentage of patients admitted from that referring hospital, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital. Under MMSEA, the 25 percentage threshold is increased to 50 percent for applicable LTCH HwHs, satellites, and grandfathered satellites.

- For urban single or MSA dominant referring hospitals, we would allow the LTCH or LTCH satellite to admit from the host up to the referring hospital's percentage of total Medicare discharges in the MSA. A floor of 25 percent and a ceiling of 51 percent applied to this variation. Under MMSEA, the 50 percentage threshold is increased to 75 percent.

Transition Periods

For Medicare discharges from referring hospitals:

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**
  - This policy was finalized for FY 2005.

This payment adjustment will be phased-in over 4 years for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and

- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the hospital's cost reporting period during FY 2004 that were admitted from the host hospital.

Year 1 -- (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"

- Payments will be made under the LTCH PPS but the percentage of LTCH HwH discharges originating from the host may not exceed the percentage for such patients established for cost reporting periods during FY 2004.

Year 2 -- (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 -- (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 4 -- (cost reporting periods beginning on or after October 1, 2007 through September 30, 2008)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent or the applicable percentage described for "specific circumstances above."

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Transition Period for all LTCHs affected by the Above Described Regulations for cost reporting periods beginning on or after July 1, 2008.

NOTE: MMSEA as amended by the ARRA and further amended by the ACA changes described above applicable for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2012 for "grandfathered" LTCH HwHs and "freestanding" LTCHs.

The full payment threshold adjustment will be phased in over 3-years as follows:

Year 1 - (for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008)

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring

hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 2 - (for cost reporting periods on or after July 1, 2008 through June 30, 2009),

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 - (for cost reporting periods on or after July 1, 2009)

- All LTCHs and LTCH satellites subject to the payment threshold policy effective for RY 2008, will be subject to the 25 percent (or applicable percentage) threshold.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Implementation:

- The payment threshold policy for discharges from co-located LTCH HwHs and LTCH satellites admitted from their hosts (including grandfathered LTCH HwHs and satellites) is determined based on a location-specific basis.

- The payment threshold policy for discharges from LTCHs and LTCH satellites admitted from referring hospitals with which they are not co-located is determined based upon provider numbers for both the LTCH and the referring hospital.

For LTCHs and LTCH satellites subject to both the FY 2005 and the RY 2008 threshold payment adjustment policies

- If a co-located LTCH or a co-located referring hospital (host) shares a provider number with a hospital or satellite at another location, threshold determinations will continue to be location-specific for the co-located LTCH and host. The threshold percentage determinations will be applied to all other location or campus of either a LTCH or referring hospital in the aggregate. For example, when the policy finalized for RY 2008 is fully

phased in, a co-located LTCH (LTCH A) and host (referring hospital A) will have a 25 percent threshold under the policy finalized for FY 2005. If referring hospital A shares a provider number with a remote location (RH A'), then another 25 percent threshold will be applied to patients discharged from LTCH A that were admitted RH A'.

- We note that for cost reporting periods beginning on or after October 1, 2007, non-grandfathered co-located LTCHs, are fully phased-in to the full 25 percent (or applicable percentage threshold) for discharges admitted from their co-located hosts (under the initial 25 percent payment threshold established for FY 2005)s.

- However, for discharges admitted from non-co-located referring hospitals, these LTCH HwHs and satellites are governed by the policy finalized for RY 2008. Therefore, for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008, the 75 percent threshold will apply, and the 50 percent threshold will apply for cost reporting periods beginning on or after July 1, 2008 through June 30, 2009 as described above in this response.)

- Furthermore, under our finalized policy for RY 2008, grandfathered LTCH HwHs and satellites will be subject to the 3-year transition that we are finalizing under this new policy for <u>all</u> their discharges, both admitted from their co-located host and from other non-co-located referring hospitals.

When both policies apply:

If a patient discharged from a LTCH HwH or satellite was originally admitted from the host hospital and immediately prior to that admission to the host, the patient was being treated at the same LTCH HwH or LTCH satellite, both of the policies described in this section, the 5 percent on-site policy as well as the 25 percent policy are applicable. In such a case, the following procedures should be followed keeping in mind that the 5 percent rule affects number of discharges and the 25 percent rule affects payment.

- The on-site 5 percent computation is first in order to determine the real number of discharges.

- Focusing on the relationship between an acute host and a LTCH HwH/satellite, if the number of revolving door discharges between these two facilities exceeds 5 percent during a CR period, this policy will collapse the number of discharges within that CR period, halving the # of revolving door LTCH stays where the intervening stay exceeded the threshold and eliminating from consideration those host stays that were bracketed by two LTCH stays. All such stays for the entire cost reporting period will be paid as one LTCH PPS stay.

- The next issue is to determine which of these stays will be paid an unadjusted LTCH PPS rate and which will be paid an amount equivalent to what would otherwise be paid under the IPPS. Cases prior to tripping the 25 percent threshold will be paid the otherwise unadjusted LTCH PPS rate and those after the threshold that had not achieved outlier status at the host it will be paid based on the adjustment.

- Because of the 5 percent policy that collapsed the discharges from the LTCH, for purposes of the 25 percent policy, we are focusing on fewer discharges in total from the LTCH and we need to determine what percent of these discharges originated in the host so that we can apply the payment adjustment.

BUT, in the event that the 5 percent is not tripped during that cost reporting period, each acute-->LTCH-->acute--> LTCH cycle, which will count as two LTCH discharges originating in the host for purposes of the 25 percent policy, since both the first and second LTCH admission were from the host.

150.9.1.5 - High Cost Outlier Cases

(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Additional payments are made for those cases that are considered high cost outliers. A case falls into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). (Short-stay outliers, described above, are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short-stay outlier cases.)

The fixed loss amount is determined annually on July 1 such that projected outlier payments are equal to 8 percent of total LTCH PPS payments. July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

If the estimated cost of the case is greater than the outlier threshold an additional payment is added to the LTC-DRG payment amount.

The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

For discharges occurring on or after August 8, 2003, (high cost outlier payments may be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 - 34513).

150.10 - Facility-Level Adjustments

(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "appropriate adjustments to the long-term hospital payment system."

Variables examined include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

- The system includes an area wage adjustment that is being phased in over 5 years.
- The wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.

- A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under http://www.ssa.gov/OP_Home/ssact/title18/1886.htm §§1886(d)(8) - (10) of the Act. Effective July 1, 2005, an LTCH wage index is based on the Core-Based Statistical Area (CBSA).

- The phase-in of the wage index adjustment is as follows:

Cost Reporting Periods Beginning During	**Applicable Wage Index Value**
FY 2003	1/5th of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2004	2/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2005	3/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2006	4/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2007	Full value (5/5^{ths}) of the value of the applicable pre-reclassification, no floor hospital inpatient wage index

Based on analyses of patient charge data from FYs 2000 and 2001 MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there is no empirical evidence to support other adjustments. Therefore, for the present, there are no adjustments for DSH, IME, or geographic reclassification.

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

- The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the acute care hospital inpatient PPS).

- Annual updates for the LTCH PPS appear in **Federal Register** publications: for payment rates and associated adjustments, see the LTCH PPS final rule with an effective date of July 1. Annual updates of the LTC-DRGs are published in the IPPS final rule with an effective date of October 1.

- The COLA factors effective July 1, 2004 are the same as under the acute care hospital inpatient PPS and are as follows:

Area	**COLA**
Alaska:	
All Areas	1.25
Hawaii:	
Honolulu	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals Area Cost of Living Adjustment Factor effective for discharges on and after October 1, 2008.

Alaska:
City of Anchorage and 80-kilometer (50-mile) radius by road 1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road 1.24
City of Juneau and 80-kilometer (50-mile) radius by road 1.24
Rest of Alaska 1.25

Hawaii:
City and County of Honolulu 1.25

County of Hawaii 1.17
County of Kauai 1.25
County of Maui and County of Kalawao 1.25

150.10.1 - Phase-in Implementation
(Rev. 1, 10-01-03)

The PPS for LTCHs is to be phased-in over a five- year period from cost-based reimbursement to Federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	**LTCH PPS Federal Rate Percentage**	**TEFRA Rate Percentage**
October 1, 2002, through September 30, 2003	20	80
October 1, 2003, through September 30, 2004	40	60
October 1, 2004, through September 30, 2005	60	40
October 1, 2005, through September 30, 2006	80	20
October 1, 2006	100	0

The LTCHs can exercise a one-time irrevocable option to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment. To exercise this option, for cost reporting periods beginning on or after October 1, 2002, and before December 1, 2002, the LTCH was to notify its A/B MAC (A) of this election in writing, and it was to be received by the A/B MAC (A) no later than November 1, 2002. To exercise this option, for cost reporting periods beginning on or after December 1, 2002, the LTCH must notify its A/B MAC (A) in writing 30 days prior to the start of the LTCH's next cost reporting period.

Payments to new LTCHs, i.e., a hospital that has its first cost reporting period as a LTCH beginning on or after October 1, 2002, are made based on 100 percent of the standard Federal rate.

NOTE: under the BIPA, during cost reporting periods beginning during FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the TEFRA portion of transitions payments.

150.11 - Requirements for Provider Education and Training
(Rev. 1, 10-01-03)

Training resources are available for A/B MAC (A) staff to use in training providers about the Long Term Care Hospital Prospective Payment System (LTCH PPS). The train-the-trainer process for LTCH PPS does not include in- person instruction for A/B MACs (A). Instead, CMS provides various educational resources for A/B MACs (A) to learn about LTCH PPS.

The CMS provides the following LTCH PPS education resources for A/B MACs (A):

- A training guide is available on; http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/ltch_train.html, the actual Training Guide can then be downloaded;

- A training video was mailed to A/B MACs (A);

- A PowerPoint presentation for training providers is available on http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/ltch_train.html, the actual Power Point presentation can then be downloaded; and

- An e-mail mailbox was established to address questions. Send questions to: LTCHPPS@cms.gov .

150.12 - Claims Processing and Billing
(Rev. 1, 10-01-03)

150.12.1 - Processing Bills Between October 1, 2002, and the Implementation Date
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Claims submitted prior to implementation were processed under the current methodology. On or after January 1, 2003, submit mass adjust claims under the PPS payment methodology by April 30, 2003. The shared systems is creating a mass adjustment program.

Beginning October 16, 2003, all LTCHs are required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD. All ICD coding must be used for LTCH providers with cost reporting period beginning on or after October 1, 2002.

150.13 - Billing Requirements Under LTCH PPS
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to

incorporate the following so that A/B MACs (A) accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X.

This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of diagnosis codes reported on the claim for the principal diagnosis, up to twenty four additional diagnoses, and up to twenty five procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper software will determine DRG assignment.

Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill (note that the day in which benefits exhaust is considered a "discharge" for payment purposes).

Effective December 3, 2007, once a patient's Medicare benefit's exhaust, the LTCH is allowed to submit no-pay bills until physical discharge or death.

150.14 - Stays Prior to and Discharge After PPS Implementation Date
(Rev. 1, 10-01-03)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under LTCH PPS, payment to the facility is based on LTCH PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider needs to submit cancels for all bills and then rebill once the cancels are accepted.

150.14.1 - Crossover Patients in New LTCHs
(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to a LTCH, payment issues arise for "cross-over" patients who were admitted prior to the change in classification who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as hospitals and generally be paid under the IPPS, for 6 months prior to designation as a LTCH, in 42 CFR 412.23(e), there are "cross-over patients," at the creation of every LTCH, who were admitted to the facility when it was an acute care hospital. The policy was to discharge the patient under the acute provider number and readmit the patient under the new LTCH provider number (see section 100.4.1 of this chapter). Medicare paid twice for what was really one episode of care since separate payment would be made to both the acute hospital and the LTCH. Effective October 1, 2004, Medicare will issue <u>one</u> discharge-based payment to the LTCH that discharges the patient, under the applicable payment system.

In the regulations at 42 CFR 412.521(e) we provide a payment methodology for such cases in which Medicare will consider all the days of the patient stay in the facility (both

prior to and following the date of LTCH designation) to be a single episode of LTCH care. Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Furthermore, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3).

Bills paid to the facility for crossover patients when the facility was paid under IPPS must be canceled, so that the entire stay can be billed under the LTCH provider number and paid for under LTCH PPS.

150.15 - System Edits

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The Shared systems and/or Common Working File (CWF) must ensure:

- That revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- That the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;

- That Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the LTCH in a specified amount of time). See section 150.9.1.2.

If the interruption is greater than the specified number of days applicable to the specific provider, the bill is considered a discharge and two bills would exist if the beneficiary returns to the same LTCH, otherwise it is considered an interruption with one DRG payment associated. CWF will edit for both of these situations.

Payments under the onsite discharge and readmittance policy are to be reconciled at cost report settlement, at which time it is possible to determine the total number of such cases that have occurred during that cost reporting period.

The accommodation revenue code 018X, (leave of absence) continues to be used in the current manner in terms of Occurrence Span code 74 and date range.

150.16 - Billing Ancillary Services Under LTCH PPS

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes are shown, in conjunction with the appropriate entries in Service Units and Total Charges.

- LTCHs are required to report the number of units based on the procedure or service.

- LTCHs are required to report the actual charge for each line item, in Total Charges.

- In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS.

150.17 - Benefits Exhausted

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The day benefits exhaust is considered a “discharge” for payment purposes under LTCH PPS.

If a beneficiary's Part A benefits exhaust during the stay, providers code an Occurrence Code A3-C3. If benefits are exhausted prior to the stay, hospitals submit a no-pay claim that is to be coded by the A/B MAC (A) with no pay code B.

LTCH PPS uses Occurrence Code 47 to indicate the first full day of cost outlier status and also uses Occurrence Span Code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

150.17.1 - Assumptions for Use in Examples Below

(Rev. 1, 10-01-03)

1. Cost outlier threshold amount is $50,000

2. Threshold amount is reached on the 25th day

3. The DRG ALOS equals 12 days, therefore, the Short Stay Threshold equals 10 days

4. Billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter

5. Beneficiary elects to use any available LTR days

150.17.1.1 - Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)
(Rev. 1, 10-01-03)

1a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 9 coinsurance and 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 9

LTR days used: 21

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

1b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 coinsurance and 0 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 9

LTR days used: 0

Cost report days: 9

OC A3: 1/09/03

Reimbursement: Short stay outlier

1c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 9 coinsurance and 10 LTR

Covered days: 19

Noncovered days: 11

Coinsurance days used: 9

LTR days used: 10

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/20/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.2 - Example 2: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

(Rev. 1, 10-01-03)

2a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 15 coinsurance and 60 LTR

Covered days: 20

Noncovered days: 10

Coinsurance days used: 15

LTR days used: 5

Cost report days: 30

OC 47: 1/26/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

2b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 15 coinsurance and 3 LTR

Covered days: 18

Noncovered days: 12

Coinsurance days used: 15

LTR days used: 3

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

2c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 15

Coinsurance days used: 15

LTR days used:0

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.3 - Example 3: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (20 day stay)

(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/21/03

Medically necessary days: 20

Covered charges: $45,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 5

Coinsurance days used: 15

LTR days used: 0

Cost report days: 20

OSC 70: 1/16/03 - 1/20/03

Reimbursement: Full DRG payment

150.17.1.4 - Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)
(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 0

LTR days used: 9

Cost report days: 9

OC A3: 1/09/03
Reimbursement: Short stay outlier payment

150.17.1.4 - Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)
(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 0

LTR days used: 9

Cost report days: 9

OC A3: 1/09/03
Reimbursement: Short stay outlier payment

150.17.1.5 - Example 5: Only LTR Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

5a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 12 LTR

Covered days: 12

Noncovered days: 18

Coinsurance days used: 0

LTR days used: 12

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/13/03 - 1/25/03

Reimbursement: Full DRG payment

5b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 0

LTR days used: 30

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

5c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 28 LTR

Covered days: 28

Noncovered days: 2

Coinsurance days used: 0

LTR days used: 28

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

150.18 - Provider Interim Payment (PIP)
(Rev. 1, 10-01-03)

PIP applies to LTCH PPS. Outlier payments in regards to PIP are handled the way they currently are under other inpatient PPS systems.

150.19 - Interim Billing
(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Interim bills are allowed every 60 days. Refer to Chapter 1, section 50.2 for specifics on interim billing under PPS.

Effective December 3, 2007, LTCHs are allowed to submit no-pay bills (TOB 110) once benefit's exhaust, every 60 days. They do not have to continually adjust bills until physical discharge or death once benefit's exhaust. The last bill shall contain a discharge patient status code.

150.20 – Intermediary Benefit Payment Report (IBPR)
(Rev. 1, 10-01-03)

The IBPR report changes to reflect the payments for LTCHs going to PPS free-standing hospitals.

150.21 - Remittance Advices (RAs)
(Rev. 1, 10-01-03)

Reason and remark codes already in existence for inpatient hospital PPS apply under this PPS.

150.22 - Medicare Summary Notices (MSNs)
(Rev. 1, 10-01-03)

Use existing notices for inpatient hospital PPS for LTCH PPS.

150.23 - LTCH Pricer Software
(Rev. 1, 10-01-03)

The CMS developed a LTCH Pricer program that calculates the Medicare payment rate.

Pricer software is electronically supplied to the Shared systems. Pricer pays a short-stay outlier if the stay is between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG.

- Pricer incorporates the five-year phase-in period for those providers that choose to be paid on the blended rate.

150.23.1 - Inputs/Outputs to Pricer

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Inputs

- Provider Specific File Data; Fields-1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25 (although this field refers to the operating cost/charge ratio, for LTCH, entered here will be a combined operating and capital cost/charge ratio). Effective July 1, 2005, A/B MACs (A) shall no longer populate fields 12, 13, or 14. Field 35 must be populated for all LTCHs. Fields 33 and 38 shall be populated if applicable. Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required. See the section "Determining the Cost-to-Charge Ratio" below for determining the cost/charge ratio.

- The facility-specific rate (Field 21) will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS were not being implemented.

- Bill Data
    - Provider #
    - Patient Status
    - Covered Charges
    - Discharge Date (or benefit's exhaust date if present (Occurrence Code A3, B3, or C3))
    - Length of Stay (LOS)
    - Covered Days
    - Lifetime Reserve Days (LTR)
    - DRG (from Grouper)

Outputs

- PPS Return Code

- MSA/CBSA (CBSAs will be returned for discharges on or after July 1, 2005).
- Wage Index
- Average LOS
- Relative Weight
- Final Payment Amount
- DRG Adjusted Payment Amount
- Federal Payment Amount
- Outlier Payment Amount
- Payment Amount
- Facility Costs
- LOS
- Regular Days Used
- LTR Days Used
- Blend Year, 1-5
- Outlier Threshold
- DRG
- COLA
- Calculation Version Code
- National Labor Percent
- National Non-Labor Percent
- Standard Federal Rate
- Budget Neutral Rate
- New Facility-specific Rate

150.24 - Determining the Cost-to-Charge Ratio
(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

For all LTCHs, effective October 1, 2003, Medicare contractors are to use a CCR from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a LTCH's CCR.

A. - Calculating an overall LTCH Medicare Cost-to-Charge Ratio

For the LTCH PPS outlier calculations (short stay and high cost), Medicare's portion of hospital costs are determined by using a hospital's overall Medicare cost-to-charge ratio (CCR). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issues a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and a Notice of Program Reimbursement (NPR) is issued.

The Medicare contractor shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Under the LTCH PPS, the following methodology shall be used to calculate a hospital's overall Medicare cost-to-charge ratio:

1) Identify total Medicare inpatient costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101)

2) Identify total Medicare inpatient charges obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data).

3) Determine the LTCH's overall Medicare CCR by dividing the amount in step 1 by the amount in step 2.

B. - Use of Alternative Data in Determining CCRs For LTCHs

Effective August 8, 2003, the CMS Central Office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, a CCR may be revised more often if a change in a LTCHs operations occurs which materially affects a LTCH's costs and/or charges. The CMS Regional Office, in conjunction with the CMS

Central Office, must approve the Medicare contractor's request before the Medicare contractor may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all LTCH claims processed after the update. Medicare contractors shall send notification to the CMS Central Office via email to outliersIPPS@cms.gov.

C. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the LTCH PPS

Medicare contractors shall continue to update a LTCH's CCR (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). A revised CCR shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

D. - Request for use of a Different CCR by CMS, the Medicare Contractor or the LTCH

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a LTCH will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The LTCH is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the LTCH, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of any such request. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request by the LTCH or Medicare contractor for use of a different CCR. Medicare contractors shall send requests via email to the CMS Central at outliersIPPS@cms.hhs.gov.

E. - Notification to Hospitals Under the LTCH PPS of a Change in the CCR

The Medicare contractor shall notify a LTCH whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a LTCH about a change to their CCR.

F. - Mergers, Conversions and Errors with CCRs

Effective April 1, 2011, for LTCHs that merge, Medicare contractors shall continue to use the CCR from the LTCH with the surviving provider number. If a new provider number is issued, as explained in §150.25 below, Medicare contractors should use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR §§ 412.525(a)(4)(iv)(C)(1) and 412.529(c)(3)(iv)(C)(1), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider

agreement). However, the policy of §150.24 part B and C can be applied to determine an alternative to the Statewide average CCR.

For newly classified LTCHs, that is those hospitals (e.g., short term acute, psychiatric, or rehabilitation hospitals) that meet the requirements set forth in 42 CFR 412.23(e), or LTCHs that receive a new LTCH provider number, the Statewide average CCR should be used until a CCR can be computed from the LTCH's cost report data, as described in part A of this section. However, as noted in part C above, the Medicare contractor or the LTCH may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report immediately preceding its classification as a LTCH or receiving a new LTCH provider number. The Medicare contractor must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS Central and Regional Offices. **NOTE: A newly classified LTCH must request an alternative CCR and receive approval from the CMS Central Office prior to the effective date of the hospital's classification as a LTCH in order for that alternative CCR to be effective beginning on the date of classification (as a LTCH). If the request and approval for an alternative CCR occurs after the effective date of the LTCH classification, then the use of the alternative CCR will be effective prospectively beginning with the date of the approval of the alternative CCR request.**

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors shall contact the CMS regional and Central Office for further instructions. Medicare contractors may contact the CMS Central Office via email at outliersIPPS@cms.hhs.gov.

G. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: 21 -Case Mix Adjusted Cost Per Discharge, 23 -Intern to Bed Ratio, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio and 28 -Medicaid Ratio. A separate history outside of the PSF is not necessary. (**NOTE**: PSF elements 23, 24, 27, 28 and 49 are only required for LTCHs effective 7/11/06.). The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

150.25 - Statewide Average Cost-to-Charge Ratios
(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For discharges prior to August 8, 2003, the Statewide average CCR is used in those instances in which a LTCH's CCR falls above or below reasonable parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's IPPS annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the Medicare contractor should use a Statewide average CCR if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances:

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 489.18.)

2. LTCHs whose overall CCR is in excess of 3 standard deviations above the corresponding national geometric mean. Effective 10/1/2006, this mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §§412.525(a)(4)(iv)(c)(2) and 412.529(c)(3)(iv)(c)(2) of the CFR.

3. Other LTCHs for whom accurate data with which to calculate an overall CCR are not available.

However, the policies of §150.24 part B and C can be applied as an alternative to the Statewide average CCR.

For those LTCHs assigned the Statewide average CCR, the CCR must be updated every October 1 based on the latest Statewide average CCRs published in each year's IPPS annual notice of prospective payment rates (Table 8C for LTCHs) until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of §150.24 part B and C of this manual. A hospital is not assigned the Statewide average CCR if its CCR falls below 3 standard deviations from the national mean CCR. In such a case, the LTCH CCR is used.

150.26 - Reconciliation
(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

A. - General

For all LTCHs, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS Central Office, Medicare contractors shall reconcile a LTCHs outlier claims at the time of cost report final settlement if they meet the following criteria:

1. The actual CCR is found to be plus or minus 10 percentage points from the CCR used during that cost reporting period to make outlier payments, and

2. Applicable outlier payments exceed $500,000 in that cost reporting period.

For the purposes of determining whether outlier payments meet the $500,000 threshold, MACs shall combine the following applicable payments depending on the cost reporting period:

a. For cost reporting periods beginning before October 1, 2015, high cost outlier payments made under 42 CFR §412.525 and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SHORT STAY OUTLIER PAYMENTS" on PS&R Report 11S);
b. For cost reporting periods beginning on or after October 1, 2015 and ending before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS" on PS&R Report 11S);
c. For cost reporting periods beginning on or after October 1, 2015 and ending after October 1, 2017
    i. For discharges before October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)), and short-stay outlier payments made under 42 CFR §412.529 ("OUTLIER" and "SSO STANDARD PAYMENTS on PS&R Report 11S);
    ii. For discharges after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S); or
d. For cost reporting periods beginning on or after October 1, 2017, high cost outlier payments made under 42 CFR §412.525 (that is, both high cost outlier payments made to site neutral payment rate discharges described under 42 CFR §412.522(a)(1) and to standard payment rate discharges described under 42 CFR §412.522(a)(2)) ("OUTLIER" on PS&R Report 11S).

To determine if a LTCH meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall

be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §150.28. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete. The criteria above replaces the criteria published in §III of PM A-03-058.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent via email to outliersIPPS@cms.hhs.gov.

Even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the CMS Central Office via email to outliersIPPS@cms.hhs.gov. Upon approval of the CMS regional and Central Office that a LTCH's high cost and short stay outlier claims need to be reconciled, Medicare contractors shall follow the instructions in §§150.27 and 150.28.

B. Reconciling Outlier Payments

Beginning with the first cost reporting period starting on or after October 1, 2003, all LTCHs are subject to the reconciliation policies set forth in this section. If a LTCH meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §150.28. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§150.27 and 150.28. The following examples demonstrate how to apply the criteria for reconciliation:

Example A

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report).

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.50.

Total outlier payments (short-stay and high cost outliers combined) in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 (by more than 10 percentage points) at the time of final settlement, and the provider received greater than $500,000 in (short-stay and high cost) outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor notifies the CMS Regional Office and CMS Central Office. The

provider's outlier payments for this cost reporting period will be reconciled using the actual CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractor shall calculate a weighted average of the CCRs in that cost reporting period. (See Example B below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted average CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total (combined short- stay and high cost) outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

Example B

Cost Reporting Period: 01/01/2004-12/31/2004

CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR is from the tentatively settled 2001 cost report)
- 0.50 from 04/01/2004-12/31/2004 (This CCR is from the tentatively settled 2002 cost report)

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total (short-stay and high cost) outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Weighted Average CCR: 0.474, completed as follows:

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	***366**		**(a)+(b) =0.4742**

***NOTE**: There are 366 days in the year because 2004 was a leap year.

The LTCH meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed (by more than ten percentage points) from 0.474 to 0.35 at the time of final settlement, and the provider received (combined) outlier payments greater than $500,000 for the entire cost reporting period.

150.27 - Time Value of Money
(Rev. 2242, Issued: 06-17-11, Effective: 07-01-11, Implementation: 07-01-11)

At the time of any reconciliation under §150.26, outlier payments may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the LTCH's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If a LTCH's outlier payments have met the criteria for reconciliation, the Medicare contractor shall follow the process in §150.28. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at
http://www.ssa.gov/OACT/ProgData/newIssueRates.html

The following formula will be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation.

NOTE: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

Example C

Cost Reporting Period: 01/01/2004-12/31/2004

Midpoint of Cost Reporting Period: 07/01/2004

Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has total outlier payments greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional Office and CMS Central Office.

The Medicare contractor reprices the claims in accordance with the process in §150.28 below. The repricing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money: (4.625 / 365) * 549 = 6.9565%

Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.

150.28 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 4390, Issued: 09-06-19, Effective: 10-01-19, Implementation: 10-07-19)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a LTCH is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via email to outliersIPPS@cms.hhs.gov and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by

entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

*__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

7) Type of Bill (TOB) equals 11X
8) Previous claim is in a paid status (P location) within FISS
9) Cancel date is 'blank'

10) The Medicare contractor reconciles the claims through the applicable LTCH Pricer software and not through any editing or grouping software.

11) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

12) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

13) For hospitals paid under the LTCH PPS, the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short-stay and high cost outlier payment amount and the revised short-stay and high cost outlier payment amount. If the difference between the original and revised PPS Payment Amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised PPS Payment is negative, then a debit amount (deduction) shall be issued to the provider.

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.

15) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original PPS amount by summing lines 1.02 and 1.05 from Worksheet E-3, Part I, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see §3633.1 of the Provider Reimbursement Manual, Part II.

16) For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original PPS amount from Worksheet E-3, Part IV line 3, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part IV of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 20 of Worksheet E-3, Part IV.

17) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

18) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the

LTCH PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 - Operating Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the Central Office, via email at outliersIPPS@cms.hhs.gov.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)

List of Data Elements for FISS Extract
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; ‘Y’ = MSP, ‘blank’ = no MSP
Reason Code
HMO-IME Indicator
Filler

160 - Necessary Changes to Implement Special Add-On Payments for New Technologies

(Rev. 1, 10-01-03)
A-02-124

160.1 - Special Add-On Payments For New Technologies

(Rev. 1, 10-01-03)

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 200l, final rule (66 FR 46902), CMS established that

cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, **if the total covered costs of the discharge exceed the DRG payment for the case** (including adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH) but excluding outlier payments). PRICER calculates the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for eligible cases is equal to:

- The full DRG payment (see example 1 that follows); plus

- The lesser of

    1. 50 percent of the costs of the new medical service or technology (see example 2); or

    2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment (see example 3); plus

- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

This instruction implements the above payment mechanism into the claims processing systems.

Below are three illustrative examples of this policy for cases involving an eligible technology estimated to cost $3,000 in a DRG that pays $20,000.

Example One

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $19,000. Medicare would pay $20,000, the full DRG payment. Even though the case involved a new technology eligible for add-on payments, the total covered costs of the case did not exceed the DRG payment, therefore, no additional payment is made.

Example Two:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $25,000. Because, in this case, 50 percent of the costs of the new medical service or technology is less than 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment, Medicare would pay 50 percent of the costs of the new technology (in addition to the DRG payment). Therefore, for this case, Medicare would pay $21,500 (the DRG payment of $20,000 plus one-half of $3,000, the estimated cost of the new technology).

Example Three:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $22,000. Medicare would pay one-half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology. Therefore, for this case, Medicare would pay $21,000 (the DRG payment of $20,000 plus one-half of the costs above that amount).

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Technologies eligible for add-on payments are identified based on the applicable codes from the International Classification of Diseases, Clinical Modification. Claims submitted with an ICD code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers pass (if present) the "principal" and up to twenty four "other procedure" codes to PRICER. If an eligible code is present, PRICER calculates an add-on payment if appropriate.

Additionally, the National Uniform Billing Committee has approved value code 77 for use on the ASC X12 837 institutional claim or Form CMS-1450 for A/B MAC (A) use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code must be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

160.1.2 - Remittance Advice Impact

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

In order to process this special add-on payment for new technologies, and report in the Remittance Advice (electronic and paper), contractors shall submit code ZL in the AMT segment of the Loop 2110 AMT01 of the ASC X12 835 Transaction. Contractors shall also submit code CS in the composite data element of the PLB segment in the 835 ASC X12 Transaction.

For PIP payment, the contractor includes only the add-on payment on a claim-by-claim basis.

The following reflects the remittance advice messages and associated codes that will appear when processing claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: OA
CARC: 94
RARC: N/A
MSN: N/A

170 - Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI) Claims

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.1 - RNHCI Election Process

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

See Chapter 5, Section 40 of Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual for a definition of RNHCI providers. See Chapter 1, Section 130 of Pub. 100-02, Medicare Benefit Policy Manual for more information about the RNHCI benefit and coverage.

170.1.1 - Requirement for RNHCI Election

(Rev. 2930, Issued: 04-11-14, Effective: 07-14-14, Implementation: 07-14-14)

The RNHCI benefit provides only for Part A inpatient services. For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

All submissions regarding RNHCI services are processed by a single Medicare contractor as a specialty workload. Currently, this specialty workload is part of Medicare Administrative Contractor Jurisdiction 10. The completed election form must be filed with the contractor and a copy retained by the RNHCI provider. See section 170.1.3 below for instructions on the submission of the election to the contractor.

The RNHCI provider should question each beneficiary prior to executing the election statement to determine if the beneficiary has Medicare Part B coverage in effect via a health plan or has recently received care (services or items, including physician-ordered durable medical equipment) for which Medicare payment was sought. An affirmative

answer will alert the RNHCI provider that subsequent claims under the election may be denied.

Occasionally, a Medicare beneficiary may seek services at a RNHCI that do not qualify for Medicare coverage and for which the beneficiary may seek payment from another insurer. The beneficiary is not required to make an election of RNHCI benefits in this case.

If the other insurer requires a denial from Medicare before making payment for these services, a denial notice cannot be processed by Medicare claims processing systems. Medicare systems require submission of a Notice of Election (NOE) before any RNHCI claims, including claims for denial, can be processed.

The RNHCI may request in writing a denial notice from the Medicare contractor. The written request must describe the reason the beneficiary does not qualify for Medicare coverage. It must also describe the specific services that will be provided to the beneficiary. In response, the contractor will provide the RNHCI with a manual denial letter. This letter may then be submitted to a secondary insurer as evidence of a prior Medicare denial**.**

170.1.2 - Revocation of RNHCI Election

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Under §1821(b)(3), a beneficiary may revoke an election in writing or by receiving nonexcepted medical care. Once an election has been revoked, Medicare payment cannot be made to an RNHCI unless a new valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage. Multiple revocations may affect the beneficiary's ability to access the RNHCI benefit in the future (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130.2.2).

Written revocations received from a beneficiary must be filed by the RHNCI with their Medicare contractor and a copy retained by the RNHCI provider. Revocations may be filed using the same format as elections, indicating a revocation in the type of bill code. See section 170.1.3 below for details.

170.1.3 - Completion of the Notice of Election for RNHCI

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Elections, revocations and cancellations of elections may be submitted to the contractor via the paper Form CMS-1450 or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ASC

X12 837 institutional claim format) does not support the data requirements of these transactions.

This section gives detailed information only for items required for the notice of election and related transactions. The RHNCI does not need to complete items not listed.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction.

The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit - Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D - Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the contractor for processing.

Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

Required - (If available) The RNHCI enters the month, day, and year of birth. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000.

National Provider Identifier

Required - The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's Medicare card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient's HICN. The RNHCI enters the number as it appears on the patient's Medicare Card, Social Security Award Certificate, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, etc., or as reported by the Social Security Office.

170.1.4 - Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

The Medicare contractor with RNHCI specialty workload submits all RNHCI election, revocations and cancelled elections to CWF for approval. The CWF will notify the contractor that these transactions were received and accepted. The CWF uses these records to maintain a beneficiary file of all RNHCI beneficiary elections and revocations. This file is used in processing claims for RNHCI services (see section 170.3 below) and for other Medicare services (see section 180).

CWF rejects any notices of revocations or cancellations when:

- CWF history shows no RNHCI elections are on file;
- The submitted dates do not match the elections on file;
- The revocation date is prior to the date of the election;
- The election in question has already been revoked or cancelled; or
- CWF history indicates an RNHCI claim has been processed during the election period to which the revocation or cancellation applies. If these claims were submitted in error, the RNHCI must cancel the claims prior to resubmitting the revocation or cancellation.

170.2 - Billing Process for RNHCI Services

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.2.1 - When to Bill for RNHCI Services

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

RNHCIs submit claims to their Medicare contractor in the following situations:

- At the time of beneficiary's discharge, or death.
- At the time the beneficiary's benefits are exhausted
- On an interim basis monthly.

RNHCIs submit a claim even where the charges do not exceed the beneficiary's deductible. See section 40 for instructions regarding reporting of utilization days.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev. 3075, Issued; 09-24-14, Effective: 11-12-14, ICD-10: Upon Implementation of ICD-10, Implementation: 11-12-14, ICD-10: Upon Implementation of ICD-10)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing RNHCI claims is the ASC X12 837 institutional claim transaction. Since the data structure of the ASC X12 837 institutional claim transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the Form CMS-1450 paper claim.

Both the electronic claim transaction and the paper claim form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/Medicare Record Number

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

1st Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency	**Definition**

0-Nonpayment/zero claims	Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 below.
l-Admit Through Discharge Claims	Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.
2-Interim-First Claim	Use for the first of an expected series of payment bills for the same confinement or course of treatment for which Medicare utilization is chargeable.
3-Interim-Continuing Claim	Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.
4-Interim-Last Claim	Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill is the discharge date for this confinement.
7-Replacement of Prior Claim	Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill. Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

Patient's Name

Required - The RNHCI must enter the beneficiary's last name, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The RNHCI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

Sex

Required - The RNHCI must enter an “M” for male or an “F” for female.

Admission Date

Required - The RNHCI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

Type of Admission

Required - The RNHCI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3	Elective	The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information Not Available	Self-explanatory

Point of Origin for Admission

Required - The RNHCI must enter the code indicating the beneficiary's point of origin. The RNHCI may use any valid point of origin code that applies to the particular admission.

Patient Discharge Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period. The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may enter any number of condition codes to describe conditions that apply to the billing period. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RHNCI must indicate whether the beneficiary elects to use lifetime reserve days. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68. If the beneficiary elects not to use lifetime reserve days, the RNHCI must report condition code 67.

Occurrence Codes and Dates

Conditional - The RNHCI may enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. Occurrence codes are 2 alphanumeric digits, and are reported with a corresponding date.

If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI reports occurrence code A3.

Occurrence Span Code and Dates

Conditional - The RNHCI may enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code.

If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI, the RNHCI reports occurrence span code 74.

Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, FL 4 = 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted.

Value Codes and Amounts

Required - The RNHCI must report utilization days using the value codes described below.

Covered Days - The RNHCI must use value code 80 to enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as non-covered, the day of discharge, and the day of death.

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

Non-covered Days - The RNHCI must use value code 81 to enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Non-covered days include:

- Days not falling under the guarantee of payment provision. See section 40.1. E.

- Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;

- Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them.

- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, section 50);

- Days after the date covered services ended, such as non-covered level of care;

- Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6;

- Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, section 10.6.4;

The RNHCI enters in "Remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for each category of non-covered days (e.g., "5 leave days").

Day of discharge or death is not counted as a non-covered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

Coinsurance Days - The RNHCI must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period.

Lifetime Reserve Days - The RNHCI must use value code 83 to enter the number of lifetime reserve days the beneficiary elected to use during this billing period.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Conditional - The RNHCI may at their option enter any number of other value codes and related dollar amount(s) to identify data necessary for the processing of this claim. Value codes are 2 alphanumeric digits, and a corresponding value amount. Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence.

Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line explains each charge. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	Description
0001	Total Charges

0120	Semi-Private Room
0270	Supplies (non-religious, as covered by Medicare)

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. On paper claims, the RNHCI must enter revenue code "000l" to report a total of the charges on the claim.

The RNHCI should list revenue codes other than revenue code “0001” in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible.

Units of Service

Required - The RNHCI must enter the number of days for accommodations revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a non-covered charge and you can bill the beneficiary if that is your usual practice and if the beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in non-covered charges.

Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. On paper claims, the last revenue code entered in revenue code "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

When submitting charges (covered/non-covered):

- Medicare is restricted by law and court order from paying for the religious portion of care or the training of personnel that provide that care. Additionally Medicare does not pay either based on charges or costs for training of nonmedical personnel. RNHCIs do not receive full Medicare payment for a beneficiary’s stay since the beneficiary is fiscally responsible for the religious aspects of care. Therefore, the original Medicare or Medicare health plan rate may be significantly lower than the RNHCI private pay rate that includes religious charges.

- As medical procedures are not performed in a RNHCI, the use of high cost medical supplies are not separately payable. Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads) are not separately payable in a RNHCI. The use of diapers, incontinence pads, chux/underpads, feminine hygiene products, tissues, and the materials for simple dressings (cleansing and bandaging) are included in the daily room and board portion of the charges and should not be reported separately as supplies.

- Medical equipment (e.g., wheelchair, walker, crutches) are institution inventory items for beneficiary use in the RNHCI. The use of these items during the beneficiary stay is part of the daily interim payment to the RNHCI. To receive Medicare payment for durable medical equipment (DME) following a RNHCI stay, a beneficiary would need to meet all of the criteria, including medical necessity, and obtain a physician order or prescription. A RNHCI is not authorized as a Medicare supplier and, therefore, may not offer DME items for purchase to beneficiaries.

- Nonmedical nursing personnel, for Medicare payment purposes, perform services (e.g., serving meals, assisting with activities of daily living) that are strictly nonmedical/non-religious. The statute and court order mandates only the coverage and payment under Part A for reasonable and necessary nonmedical/non-religious care.

- Medicare payment for religious/nonmedical nursing personnel in a RNHCI, as other inpatient facilities, is a component of the per diem rate and is not separately payable.

Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff, or convenience items that are not part of the Medicare daily interim payment rate.)

Examples of non-covered charges:

- Non-covered religious items include but are not limited to religious publications, religious recordings, any equipment for the use of those recordings, any reproduction costs for these materials, and attendance at religious meetings.

- Religious sessions with RNHCI staff or outside associates.

- Expenses related to student programs/subsistence, staff education/training, travel, or relocation to be factored into the development of charges for covered patient care services.

- Stays, items, and services that are not substantiated by appropriate documentation in the beneficiary's utilization review file or care record.

- Convenience items (e.g., telephone, computer, beautician/barber).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A supply information needed by the payer named. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

National Provider Identifier

Required - The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, the RNHCI must enter the beneficiary's Medicare Health Insurance Claim Number. The RNHCI must show the number as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, or as reported by the Social Security Office.

Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through" dates before implementation of ICD-10, the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause"). To satisfy this requirement on claims with Statement Covers "Through" dates on or after the implementation of ICD-10, the RNHCI may report ICD-10 code R69 (defined "illness, unspecified").

Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through"

dates before the implementation of ICD-10, the RNHCI may report ICD-9 code V62.6 (defined “refusal of treatment for reasons of religion or conscience”). To satisfy this requirement on claims with Statement Covers “Through” dates on or after the implementation of ICD-10, the RNHCI may report ICD-10 code Z53.1 (defined “procedure and treatment not carried out because of patient's decision for reasons of belief”).

The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other fields relating to medical diagnoses and medical procedures.

The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other fields relating to medical diagnoses and medical procedures.

Attending Provider

Required - While the participation of an attending provider is not consistent with the nonmedical nature of RNHCI services, reporting an attending provider is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI must report the name and NPI of their director of nursing.

Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date

Required - If using the hard copy claim, an RNHCI representative makes sure the claim record is complete and accurate before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

170.3 - RNHCI Claims Processing By the Medicare Contractor with RNCHI Specialty Workload

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Upon submission of a claim for RNHCI services, the contractor ensures that the submission contains the complete set of required data elements according to the instructions in §170.2. The specialty contractor ensures that the submission does not contain data that is invalid, internally inconsistent or is not otherwise submitted in error. If the submission is not found to be consistent with CMS instructions, it is returned to the RNHCI for correction.

Once the claim is found to satisfy CMS instructions, the contractor ensures the claim is not a duplicate of previously paid RNHCI services or does not demonstrate grounds for Medicare denial for any other reason. If the claim appears appropriate for payment based

on the specialty contractors initial processing, the claim is submitted to the CMS Common Working File (CWF) for approval.

The CWF system compares the claim submitted by the contractor to the eligibility and utilization data for the beneficiary that received the services. The CWF ensures the beneficiary is eligible for Part A for the dates of service (since RNHCI services are exclusively a Part A benefit) and the beneficiary has utilization days remaining in their current inpatient spell of illness. The CWF also compares the RNHCI claim to the beneficiary's file of RNHCI elections and claims. If CWF does not identify any error conditions on the RNHCI claim, an approval message is returned to the specialty contractor.

An RNHCI claim may be rejected by CWF if:

- No RNHCI election period is present for the dates of service of the claim;
- The RNHCI election period to which the claim would apply has been revoked (see section 180 for procedures that lead to revocation of the election);
- The RNHCI election period to which the claim would apply has been cancelled; or
- The service dates on the claim overlap previously paid claims for RNCHI services or other inpatient services that were processed by a Medicare contractor other than the specialty contractor.

Claims rejected for these reasons may not be corrected and returned by the RNHCI. If the error condition can be resolved (for instance, by the resubmission of an election period cancelled in error), the RNHCI may submit a new original claim for the services.

Upon receipt of payment approval or rejection from CWF, the contractor may then process the claim to completion. RNHCI claims are paid a daily interim rate as established for each RNHCI provider under TEFRA payment rules (see Pub. 15-2, Provider Reimbursement Manual, chapter 30). The contractor makes RNHCI payments subject to the inpatient hospital cash deductible when applicable and, if services are for the 61st through 90th day of a benefit period or are for lifetime reserve days, subject to coinsurance (see Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Sections 10.1 and 10.2).

170.3.1 - RNHCI Claims Not Billed to Original Medicare

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Health Plans

A beneficiary covered by a Medicare Advantage plan (e.g., Medicare health maintenance organization, preferred provider organization, competitive medical plan or other health care prepayment plans.) must have prior authorization from their plan before admission to

a RNHCI to assure payment for a specified time period. Continued stay reviews must be performed, submitted, and approved at designated intervals identified by the plan to assure coverage by the Medicare health plan.

In the case of billing a Medicare health plan, the RNHCI charges for inpatient services should not exceed the established interim TEFRA per diem payment amount available under Medicare Part A. The Medicare health plan may obtain the current TEFRA per diem rate information by calling the specialty contractor responsible for the involved RNHCI.

Medicaid

The State agency may obtain the current Medicare rate information by calling the Medicare contractor responsible for the RNHCI.

170.4 - Informing Beneficiaries of the Results of RNHCI Claims Processing

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. The Medicare contractor with RHNCI specialty workload uses special messages on MSNs to reflect determinations specific to the RNHCI benefit.

- If an RNHCI claim is denied because CWF did not find record of an RNHCI election in the beneficiaries record, the contractor uses MSN message 42.3. This message reads: “This service is not covered since you did not elect to receive religious nonmedical health care services instead of regular Medicare services.”

- If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary’s record that had been revoked in writing, the contractor uses MSN message 42.5. This message reads: “This service is not covered because you requested in writing that your election to religious nonmedical health care services be revoked.”

- If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary’s record that had been revoked because the beneficiary received nonexcepted medical care, the contractor uses MSN message 42.4. This message reads: “This service is not covered because you received medical health care services which revoked your election to religious nonmedical health care services.”

180 - Processing Claims For Beneficiaries With RNHCI Elections by Contractors Without RNHCI Specialty Workloads

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

While elections and claims for RNHCI services are processed by the Medicare contractor with RNHCI specialty workload, all Medicare contractors (below 'non-specialty contractors') must understand the nature and purpose of the RNHCI election and the definitions of excepted and non-excepted care defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130. Non-specialty contractors may find it advisable to have an identified specialist (or specialists) familiar with excepted and nonexcepted care used in the review of beneficiaries with RNHCI elections, since this process is so unlike other Medicare claims processes.

Beneficiaries may revoke their RNHCI election by submitting a written revocation request to Medicare, but this is rare. Far more commonly, beneficiaries revoke the election simply by receiving nonexcepted medical services and requesting Medicare payment for those services. Any non-specialty contractor may receive a claim for services for a beneficiary with an RNHCI election currently in place. This section provides instructions to non-specialty contractors for the handling of such claims.

Upon receipt of a claim for payment, non-specialty contractors will not be aware that the beneficiary has an RNHCI election in place and will process the claim normally to the point of transmitting the claim to CWF. The CWF searches beneficiary records for all claims to determine whether an RNHCI election is found. If an election is found, CWF takes one of two actions on a claim for non-RNHCI services:

- If the claim is for DME, or prosthetic/orthotic devices, CWF will accept the DMEPOS claim and revoke the RNHCI election. All DMEPOS claims are treated as nonexcepted medical care.

- If the claim is for any other Medicare covered services, CWF initially rejects it to the non-specialty contractor. The non-specialty contractor must determine whether the care was excepted or nonexcepted. The claim must never be automatically denied. The RNHCI election revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of their Medicare coverage.

The process for non-specialty contractors to follow in responding to this CWF edit is unique among Medicare claims processes. A determination must be made whether the beneficiary's RNHCI election should be revoked. Therefore, unlike other CWF rejects which are processed in an automated fashion, claims rejected by CWF due to the presence of an RNHCI election must be suspended and developed to determine if the beneficiary received excepted care.

At differing points in time, this review consisted of a request for medical records or a series of telephone contacts but these methods were found too workload intensive. In response to a CWF reject due to the presence of an RNHCI election, non-specialty contractors must issue a simple development letter asking the provider of services to respond in a yes or no fashion to three questions:

- Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare;

- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and

- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

Each non-specialty contractor may develop the wording and format of this letter based on their experience effectively communicating with their community of providers.

The purpose for this development letter is to determine whether the care received is excepted (leaving the election intact) or whether it is nonexcepted (causing a revocation of the RNHCI election). Provider responses of 'No' to all questions in the letter will determine that the services are found to be non-excepted care. Provider responses of 'Yes' to the questions regarding inability to make beliefs known or regarding required vaccinations will determine that the services are found to be excepted care. Unless reasons to deny these claims are found during the course of claims processing, these claim will normally be paid. A provider response of 'Yes' to the question regarding the beneficiary's paying out of pocket will determine that the services are found to be excepted care, but the claim for payment for medical care must be denied. The claim must be denied because the beneficiary has not made a request for Medicare payment. The beneficiary has accepted liability for these services in order to protect their RNHCI election.

Once the non-specialty contractor makes this determination of whether the care is excepted or nonexcepted, the claim record is annotated accordingly (see section 180.1 below) and returned to CWF. The claim will be approved for payment and if the care was found to be nonexcepted CWF will cause the beneficiary's RNHCI election to be revoked.

In the event that the provider does not reply timely to the development letter, non-specialty contractors must make an excepted/nonexcepted determination based on the evidence presented by the claim itself. Non-specialty contractors shall apply the same timeliness standard to these responses as to all other documentation requests. If the claim contains durable medical equipment or prosthetic/orthotic devices, the non-specialty contractor may make a determination of nonexcepted care on that basis alone. All such claims are treated as nonexcepted care. For all other claims, non-specialty contractor staff with a clinical background must make their best determination based on the diagnoses and procedures reported on the claim whether the services were excepted or nonexcepted care. In cases where the determination cannot be made with certainty but there is some reason to suspect services were nonexcepted care, the non-specialty contractor shall make a determination of nonexcepted care and annotate the claim record accordingly. Determinations must be made within the earlier of 30 days of receipt of the provider's response or 30 days of the end of the timely response period.

The importance of the development of these claims lies in its effect on the beneficiary. If the claim for medical care is denied improperly based on the presence of the RNHCI election, the beneficiary will incur liability in error and may experience financial hardship.

Similarly, it is important that the review result in accurate determinations of nonexcepted care since repeated revocations of this benefit can have an impact on the beneficiary's right to access the RNHCI benefit in the future.

180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

Once the excepted/nonexcepted care determination is made, the non-specialty contractor resubmits the claim to CWF using the following indicators to record the determination:

- Indicator "1" - for excepted care; or
- Indicator "2" - for nonexcepted care.

NOTE: Indicator 0 (zero) presents no entry.

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

Record	Location	Field	Size
HUIP (IP hospital/SNF Claim)	84	1	823
HUOP (Outpatient)	64	1	778
HUHC (Hospice)	64	1	778
HUHH (Home Health)	64	1	778
HUBC (A/B MAC (B) Claim)	13	1	57

The screen field corresponding to these CWF fields may vary depending on the Medicare shared system in use at a contractor's location. Non-specialty contractors may contact their shared system maintainer if necessary to determine the correct screen location to use for excepted/nonexcepted care indicators.

If a claim is resubmitted with a "0" excepted care indicator in error, CWF will again reject the claim. Upon receipt of the resubmitted claim with a valid "1" or "2" entry, CWF will approve it for payment and revoke the beneficiary's election if the care received was nonexcepted. CWF will **not** notify either the specialty contractor or the non-specialty contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims processed at the contractor with RNHCI specialty workload will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.

If development to make the excepted/nonexcepted care determination discovered that the beneficiary paid out of pocket for the services and the claim for payment for medical care must be denied as a result.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: PR
CARC: 96
RARC: MA47
MSN: N/A

180.2 - Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

(Rev. 2654, Issued: 02-08-13, Effective: 05-09-13, Implementation, 05-09-13)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. Non-specialty contractors use special messages on MSNs to reflect determinations specific to excepted or nonexcepted care.

- If a determination of excepted care is made, the non-specialty contractor uses MSN message 42.1. This message reads: "You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care."

- If a determination of nonexcepted care is made, the non-specialty contractor uses MSN message 42.2. This message reads: "Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services has been revoked for these services unless you file a new election."

If development to make the excepted/nonexcepted care determination discovered that the beneficiary did not request Medicare payment, but instead paid for the services out of pocket, the non-specialty contractor uses MSN message 16.41. This message reads: "Payment is being denied because you refused to request reimbursement under your Medicare benefits."

190 - Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.1 - Background

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

This section and its subsections provide instructions about the IPF PPS. The IPF PPS replaces existing reasonable cost-based payments subject to Tax Equity and Fiscal Responsibility Act (TEFRA) limits under section 1886 (b) of the Social Security Act (the Act) for discharges occurring on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at 42 CFR 412, Subpart N, provides payment for inpatient psychiatric treatment when provided to an inpatient in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs).

190.2 - Statutory Requirements

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary: (1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P. L. 108-173), section 405(g) extended the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

190.3 - Affected Medicare Providers

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Psychiatric hospitals and distinct part psychiatric units of acute care hospitals and CAHs are included in the IPF PPS and are referred to in these instructions as “inpatient psychiatric facilities” or “IPFs.” The regulations at 42 CFR 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR 412.22, 42 CFR 412.23(a), 42 CFR 482.60, 42 CFR 482.61, and 42 CFR 482.62, and units that meet the requirements specified in 42 CFR 412.22, 42 CFR 412.25, and 42 CFR 412.27.

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to mentally ill patients, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and

staffing requirements in 42 CFR 412.27 which mirror the requirements for a psychiatric hospitals in 42 CFR 482.60, 42 CFR 482.61 and 42 CFR 482.62.

The provider number ranges (OSCAR number) for IPFs are from xx-4000 through xx-4499, xx-Sxxx, and xx-Mxxx. Note that this will change with the implementation of National Provider Identifiers (NPI).

The following hospitals are not paid under the IPF PPS:

- Veterans Administration hospitals; See 42 CFR 412.22 (c).

- Hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403; Psychiatric Hospitals (provider numbers xx-4000 - xx-4499) in the State of Maryland are paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital in Maryland identified by 'S' in the third position of the OSCAR number are waived from the IPF PPS, as is the acute hospital in which they are located. Currently there are no CAHs in Maryland.

- Hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Pub. L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub. L. 92-603 (42 U. S. C. 1395b-1); See 42 CFR 412.22 (c). IPFs in acute care hospitals that participate in demonstration projects are paid in accordance with the demonstration project;

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are paid in accordance with 42 CFR 412. 22 (c).

- Payment to foreign hospitals is made in accordance with the provisions set forth in 42 CFR 413.74.

190.4 - Federal Per Diem Base Rate

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Payments to IPFs under the IPF PPS are based on a single Federal per diem base rate computed from both the inpatient operating and capital-related costs of IPFs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct graduate medical education, and nursing and allied health education).

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate (which is broken into a labor-related share and a non-labor-related share) and applicable patient and facility adjustments that are described in §§190.5 and 190.6.

The standardized Federal per diem base rates and adjustment factors are updated July 1 every year, beginning July 1, 2006. For the updated standardized Federal per diem base rates for subsequent years refer to the **Federal Register** rules and accompanying Recurring Update Notifications. See

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/IPF-PPS-Regulations-and-Notices.html

190.4.1 - Standardization Factor

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The CMS standardized the IPF PPS Federal per diem base rate in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, CMS compared the IPF PPS payment amounts calculated from the FY 2002 MedPAR file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. CMS then applied this factor to the average per diem cost of an IPF stay.

190.4.2 - Budget Neutrality

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The BBRA required that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented. Therefore, in the November 2004 IPF PPS final rule, CMS calculated the budget neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented. CMS calculated the final Federal per diem base rate to be budget neutral during the implementation period under the IPF PPS using a July 1 update cycle. The implementation period for the IPF PPS is the 18-month period of January 1, 2005 through June 30, 2006.

190.4.2.1 - Budget Neutrality Components

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The following are the three components of the budget neutrality adjustment:

(1) Outlier Adjustment: Since the IPF PPS payment amount for each stay includes applicable outlier amounts, CMS reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The appropriate outlier amount was determined by comparing the adjusted prospective payment for the entire stay to the computed cost per case. If costs were above the prospective payment plus the adjusted fixed dollar loss threshold amount, an outlier payment was computed using the applicable risk-sharing percentages. The outlier adjustment was calculated to be 2 percent of total IPF PPS. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments;

(2) Stop-Loss Adjustment: CMS provides a stop-loss payment to ensure that an IPF's total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. CMS reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. The CMS has previously stated that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition. Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39 percent.

(3) Behavioral Offset: The implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may incur higher payments than assumed in the calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, CMS reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes.

190.4.3 - Annual Update

(Rev. 10312; Issued: 08-21-2020; Effective: 10-01-20; Implementation: 10-05-20)

Prior to rate year (RY) 2012, the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) was on a July 1st - June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006 and every July 1st thereafter.

Effective with RY 2012, the IPF PPS payment rate update period switched from a rate year that began on July 1st ending on June 30th to a period that coincides with a fiscal year (FY). To transition from a RY to a FY, the IPF PPS RY 2012 covered the15 month period from July 1st -September 30th. This change to the payment update period will allow one consolidated annual update to both the rates and the ICD-10-CM/PCS coding changes (MS-DRG, comorbidities, and code first). Coding and rate changes will continue to be effective October 1st-September 30th of each year thereafter.

In accordance with 42 CFR 412.428, the annual update includes revisions to the Federal per diem base rate, the hospital wage index, ICD-10-CM coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) payment per treatment, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

Below are the Change Requests (CRs) for the applicable Rate Years (RYs) and Fiscal Years (FYs), which are issued via a Recurring Update Notification.

RY 2009 - CR 6077

RY 2010 - CR 6461
RY 2011 - CR 6986
RY 2012 - CR 7367
FY 2013 - CR 8000
FY 2014 - CR 8395
FY 2015 - CR 8889
FY 2016 - CR 9305
FY 2017 - CR 9732
FY 2018 - CR 10214
FY 2019 - CR 10880
FY 2020 - CR 11420
FY 2021 – CR 11949

Change Requests can be accessed through the following CMS Transmittals Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Inpatient-Psychiatric-Facility-PPS-Transmittals.html

190.4.4 - Calculating the Federal Payment Rate

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

To calculate an IPF PPS payment, follow the steps below:

1 - Multiply the Federal per diem base rate by the labor share.

2 - Multiply the resulting amount by the appropriate wage index factor.

3 - Multiply the Federal per diem base rate by the non-labor share.

4 - Multiply the resulting amount from this by any applicable cost-of-living adjustment (COLA) (Alaska or Hawaii).

5 - Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate (Add the results of steps 2 and 4). This is the Federal rate.

You must multiply this sum (step 5) by the all applicable facility and patient level adjustment factors described in §§190.5 and 190.6, to calculate the final payment.

CMS furnishes and maintains a PRICER program for intermediaries, and provides a PC PRICER that may be downloaded from the CMS Web site. The Web site is www.cms.hhs.gov/pcPricer

190.5 - Patient-Level Adjustments

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Patient-level adjustments include a DRG, or MS-DRG, adjustment, comorbidity adjustment, an age adjustment, and a variable per diem adjustment.

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev. 4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

On claims with discharges before October 1, 2007, the IPF PPS provides adjustments for 15 designated DRGs. On claims with discharges on or after October 1, 2007, the IPF PPS provides adjustments for 17 designated MS-DRGs. Payment is made under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the International Classification of Diseases (ICD-9- or ICD-10 as applicable) or the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision (DSM-IV-TR). The language about the source of the principal diagnosis code is from our regulations at 42 CFR 412.27, and has been in place since 2006, but there have since been updates to the versions of these code sets.

In a final rule published on September 5, 2012 (77 FR 54664), the Secretary of HHS adopted the ICD–10–CM and ICD–10–PCS, in place of the ICD–9–CM, as the standard medical data code sets for HIPAA covered entities. Because we are required to use the HIPAA standards, effective October 1, 2015, IPF claims for eligible patients must have a psychiatric principal diagnosis that is listed in the ICD–10–CM. It should be noted that the DSM codes map to ICD-10 codes, but the mapping is not exclusive to chapter 5 of the ICD–10–CM, as it was with ICD–9–CM.

Nevertheless, only those claims with diagnoses that group to a psychiatric DRG/MS-DRG will receive the DRG adjustment in addition to all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the following psychiatric DRGs/MS-DRGs, the IPF will receive the Federal per diem base rate and all other applicable adjustments.

IPFs must submit claims providing the principal diagnosis. To classify the case to the appropriate DRG/MS-DRG, the GROUPER software for the hospital IPPS is used and the IPF PRICER applies the appropriate adjustment factor to the Federal per diem base rate.

Changes to the ICD coding system are addressed annually in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS-DRGs which were effective October 1, 2007:

(v24) DRG Prior to 10/01/07	(v25) MS-DRG From 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

190.5.2 - Application of Code First

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

According to the ICD Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable coding

convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches only the first "secondary" code for a psychiatric code to assign the DRG/MS-DRG in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the CDC Web site at:

http://www.cdc.gov/nchs/icd/icd9cm.htm

The ICD-10-CM Official Guidelines are posted on the CDC's website at:

http://www.cdc.gov/nchs/icd/icd10cm.htm

The most current Code First list is posted on the IPF PPS Web site at:

www.cms.gov/InpatientPsychFacilPPS. Select Tools and Worksheets from the column at the left.

Code First Example - ICD-9-CM

Diagnosis code 294.11 "Dementia in Conditions Classified Elsewhere with Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

Four digit code 294.1 "Dementia in Conditions Classified Elsewhere", is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 "Persistent Mental Disorders Due to Conditions Classified Elsewhere" appears in the ICD-9-CM as follows:

294 - PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 - Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

Alzheimer's disease (331.0)

Cerebral lipidosis (330.1)

Dementia with Lewy bodies (331.82)

Dementia with Parkinsonism (331.81)

Epilepsy (345.0 - 345.9)

Frontal dementia (331.19)

Frontotemporal dementia (331.19)

General paresis [syphilis] (094.1)

Hepatolenticular degeneration (275.1)

Huntington's chorea (333.4)

Jacob-Creutzfeldt disease (046.1)

Multiple sclerosis (340)

Pick's disease of the brain (331.11)

Polyarteritis nodosa (446.0)

Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's Chorea" as the principal diagnosis code and 294.11 "Dementia In Conditions Classified Elsewhere With Behavioral Disturbances" as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs, or 17 MS-DRGs, for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG/MS-DRG, the PRICER would search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.

Code First Example - ICD-10-CM

Diagnosis code F02.81 "Dementia in other diseases classified elsewhere with behavioral disturbance" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

The three digit code F02 "Dementia in other diseases classified elsewhere", is designated as a Code First diagnosis indicating that all diagnosis codes that fall under the F02 category (codes F02.80 and F02.81) must follow the Code First rule. The 3 digit code F02 "Dementia in other diseases classified elsewhere" appears in the ICD-10-CM as follows:

F02 Dementia in other diseases classified elsewhere

Code first the underlying physiological condition, such as:

Alzheimer's (G30.0 - G30.9)
cerebral lipidosis (E75.4)
Creutzfeldt-Jakob disease (A81.0 - A81.09)
dementia with Lewy bodies (G31.83)
epilepsy and recurrent seizures (G40 - G40.919)
frontotemporal dementia (G31.09)
hepatolenticular degeneration (E83.0)
human immunodeficiency virus [HIV] disease (B20)
hypercalcemia (E83.52)
hypothyroidism, acquired (E00 - E03.9)
intoxications (T36 - T65)
Jakob-Creutzfeldt disease (A81.00 - A81.09)
multiple sclerosis (G35)
neurosyphilis (A52.17)
niacin deficiency [pellagra] (E52)
Parkinson's disease (G20)
Pick's disease (G31.01)
polyarteritis nodosa (M30.0)
systemic lupus erythematosus (M32 - M32.9)
trypanosomiasis (B56 - B57.39)
vitamin B deficiency (E53.8)

F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
NOT ALLOWED AS PRINCIPAL DX

F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, G20 “Parkinson’s disease” as the principal diagnosis code and F02.81 “Dementia in other diseases classified elsewhere with behavioral disturbance” as a secondary diagnosis or comorbidity code on the patient claim.

190.5.3 - Comorbidity Adjustments

(Rev. 4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and not reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay or affect both treatment and the length of stay. IPFs enter the full codes for up to twenty four additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has 17 comorbidity categories, each containing codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment.

Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-10-CM/PCS codes that are associated with each category is on the IPF PPS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/inpatientpsychfacilpps. Select Tools and Worksheets from the column at the left.

The 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	**Adjustment Factor**
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	1.13
Eating and Conduct Disorders	1.12
Infectious Disease	1.07
Drug and/or Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings - Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

190.5.4 - Age Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS has an age adjustment with 9 age categories; under 45, over 80, and categories in 5 year groupings in between. IPFs receive this adjustment for each day of the stay. The age adjustment is determined based on the age at admission and does not change regardless of the length of stay.

Age	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

190.5.5 - Variable Per Diem Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The variable per diem adjustments account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. The variable per diem adjustments decline each day of the patient's stay through day 21. After day 21, the adjustments remain the same each day for the remainder of the stay.

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 1 - Facility Without a Qualifying Emergency Department	1.19
Day 1 - Facility With a Qualifying Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00
Day 10	1.00
Day 11	0.99
Day 12	0.99

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
Over 21	0.92

*The adjustment for day 1 would be 1.31 or 1.19 depending on whether the IPF has a qualifying emergency department or is a psychiatric unit in an acute care hospital or CAH with a qualifying emergency department (see §190.6.4).

190.6 - Facility-Level Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Facility-level adjustments include the hospital wage index, a rural location adjustment, a teaching status adjustment, an emergency department adjustment for qualifying EDs, and a cost-of-living adjustment for IPFs located in Alaska and Hawaii.

190.6.1 - Wage Index

(Rev. 4406, Issued: 10-01-19, Effective: 10-01-19, Implementation: 10-07-19)

The wage index accounts for the geographic differences in labor costs. Prior to Fiscal Year 2020, the IPF PPS used the unadjusted, pre-floor, pre-reclassified hospital wage index from the prior year as the basis for the IPF wage index. Beginning with Fiscal Year 2020, the IPF PPS uses the concurrent unadjusted, pre-floor, pre-reclassified hospital wage index as the basis for the IPF wage index. The wage index is applied to the labor-related share of the Federal per diem base rate.

Core-Based Statistical Area (CBSA) designations are used for assigning a wage index value for discharges occurring on or after October 1. Updates to the IPF PPS wage index are made in a budget neutral manner. CMS calculates a budget-neutral wage index adjustment factor by comparing estimated payments under the previous wage index to estimated payments under the updated wage index. This factor is applied in the update to the Federal per diem base rate.

190.6.2 - Rural Location Adjustment
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There is a 17 percent adjustment if a facility is located in a rural area. The IPF PPS defines urban and rural areas at 42 CFR 412.402.

190.6.3 - Teaching Status Adjustment
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs that train interns and residents receive a facility-level adjustment to the Federal per diem base rate. The cost of direct graduate medical education (DGME) and nursing and allied health education are not paid through the IPF PPS.

PRICER calculates the adjustment by adding 1 to the ratio of interns and residents to the average daily census (ADC), and then raising that sum to the 0.5150 power.

The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to November 15, 2004. (See §190.6.3.1 for more detailed instructions for the FTE Resident Cap).

For beneficiaries enrolled in a Medicare Advantage plan, IPFs may bill for DGME and nursing and allied health education costs. There is no authority to pay teaching status adjustment to IPFs for Medicare Advantage beneficiaries, as is done under the IPPS.

190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. There is no limit to the number of residents teaching institutions can hire or train. There is only a limit to the number of residents who may be counted in calculation of the IPF PPS teaching adjustment. The cap is the number of FTE residents that trained in the IPF during a base year.

An IPF's FTE resident cap is determined based on the IPF's most recently filed cost report, filed prior to November 15, 2004. IPFs that first began training residents after November 15, 2004, will initially receive an FTE cap of zero. The FTE caps for new IPFs (as well as existing IPFs) that start training residents in a new DGME program (as defined in 42 CFR 413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in 42 CFR 412.424(d)(1)(iii)(B)(2)).

IPFs are not permitted to aggregate the FTE resident caps used to compute the IPF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IPF (for example, a resident on a full-time, 3-month rotation to the IPF would be counted as

0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS Indirect Medical Education (IME) adjustment is allowed to be counted for purposes of the teaching status adjustment under the IPF PPS.

The denominator used to calculate the teaching status adjustment under the IPF PPS is the IPF's ADC from the current cost reporting period. If IPFs have more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If an IPF were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility trains).

190.6.3.2 - Reconciliation of Teaching Adjustment on Cost Report

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The teaching status adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount based on information from the cost report are adjusted through lump sum payments/recoupments when the cost report is settled.

The teaching adjustment is calculated as follows:

1. Determine the product of the wage-adjusted Federal per diem base rate and the applicable teaching, rural, DRG, comorbidity, and age adjustments.

2. Determine the product of the wage adjusted base rate and the applicable rural, DRG, comorbidity, and age adjustments.

3. Determine the difference of these two products (Step 1 minus Step 2).

4. Calculate and sum the variable per diem amounts for the product in Step 2 to calculate the Federal payment net of the teaching adjustment amount.

5. Calculate and sum the variable per diem amounts for the difference in Step 3 to calculate the portion of the Federal payment attributable to the teaching adjustment.

6. To obtain the total Federal payment necessary for outlier calculations, etc., add Steps 4 and 5 together. Step 5 alone is the teaching adjustment portion of the Federal payment, and can be separately identified and reconciled on the cost report.

190.6.4 - Emergency Department (ED) Adjustment

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

An adjustment is provided for IPFs that maintain a qualifying ED. This is a facility-level adjustment that applies to all IPF admissions (with the one exception described below),

regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive a 31 percent adjustment as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 19 percent adjustment as the variable per diem adjustment for day 1 of each patient stay.

A qualifying ED means an ED of psychiatric units located in a hospital or CAH with EDs that are staffed and equipped to furnish a comprehensive array (medical as well as psychiatric) of emergency services and meets the definition of "provider-based status" (42 CFR 413.65) and meets the definition of a "dedicated emergency department" (42 CFR 489.24).

- "Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of this section." 42 CFR 413.65

- "Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

  (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

  (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

  (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." See 42 CFR 489.24.

As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF.

IPFs should notify their Medicare contractors 30 days before the beginning of their cost reporting period regarding if they have a qualifying ED. Medicare contractors have the discretion to determine how they wish to be notified and the documentation they require. Once the Medicare contractor is satisfied that the IPF has a qualifying ED, the Medicare contractor should enter the information in the provider-specific file within a reasonable timeframe so that the IPF can begin to receive the ED adjustment. Application of the ED adjustment is prospective.

Medicare contractors may also use the date the documentation was received from the IPF to implement the ED adjustment. The provider-specific file can be updated from the date of the attestation and claims processed from that date will receive the ED adjustment. CMS does not intend that IPFs would have to wait until the beginning of their next cost report period to receive the ED adjustment.

However, if an IPF no longer meets the definition of a qualified ED, the IPF must promptly notify their Medicare contractor. The Medicare contractor would immediately remove the flag from the provider-specific file and the provider will not receive the ED adjustment. If the provider should once again meet the definition of a qualified ED, they should contact their Medicare contractor immediately in order to update their file.

190.6.4.1 - Source of Admission for IPF PPS Claims for Payment of ED Adjustment

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Source of admission code "D" is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital or CAH. Claims with source of admission code "D" do not receive the ED adjustment.

See Pub. 100-04, Medicare Claims Processing Manual chapter 25, §60.1, for additional instructions for completing the CMS claim data set.

190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii

(Rev. 4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the area in which the IPF is located. An adjustment for IPFs located in Alaska and Hawaii is made by multiplying the non-labor related share of the Federal per diem base rate and ECT rate by the applicable COLA factor.

The CMS notes that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR §591.207, the OPM established the following COLA areas:

(a) City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;
(b) City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(c) City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(d) Rest of the State of Alaska.

In FY 2018, we updated the IPF COLA amounts; these updated amounts will remain in effect for FY 2018 through FY 2020.

State	Location	COLA
Alaska	Anchorage	1.25
	Fairbanks	1.25
	Juneau	1.25
	Rest of Alaska	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.21
	Kauai County	1.25
	Maui County	1.25
	Kalawao County	1.25

190.7 - Other Payment Policies

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.7.1 - Interrupted Stays

(Rev. 2083, Issued: 10-29-10, Effective: 01-01-11, Implementation: 01-03-11)

An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

For a patient who is discharged and readmitted to the same IPF, interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for an outlier payment. In other words, an interrupted stay is treated as one stay and one discharge for the purpose of payment. Thus, the IPF should hold the claim for 3 days to ensure there is not a readmission that soon. In this way, the readmission is included on the original claim.

For example, if a patient leaves the IPF on 1/1 and returns to the same IPF on 1/3, this is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills are allowed.

For a patient who is discharged and readmitted to another IPF, interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment.

For example, if a patient is discharged from IPF "A" and within 3 days is readmitted to IPF "B," this is considered an interrupted stay under IPF PPS. There will be no provider action. FISS will process the claim from IPF "B" with information received from CWF on covered days from the claim received from IPF "A"(this information will be displayed in FISS with a value code 75 on claim that is processed for IPF "B").

Medicare contractors should monitor trends to ensure IPFs are not consistently admitting, discharging, and readmitting patients in order to receive the larger variable per diem payments associated with the first days of a patient's stay.

190.7.2 - Outlier Policy

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

§124 of the Medicare, Medicaid, and SCHIP, Balance Budget Refinement Act of 1999 (BBRA) (Pub.L.106-113), mandated the development of a per diem prospective payment system for inpatient psychiatric services furnished in hospitals and psychiatric distinct part units of acute care hospitals. §405 (g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(MMA) (Pub. L. 108-173) extended the IPF PPS to distinct part psychiatric units of critical access hospitals (CAHs). §124 of the BBRA provides the Secretary discretion in establishing the payment methodology including payments for cases incurring extraordinarily high costs. This additional payment known as an "outlier" is designed to protect IPFs from large financial losses due to unusually expensive cases. If the estimated cost of the case is greater than the adjusted fixed dollar loss threshold amount (the fixed dollar loss threshold amount multiplied by area wage index, rural location, teaching and COLA adjustment factors), an additional payment is added to the IPF PPS payment amount.

The fixed dollar loss threshold amount is computed so that projected outlier payments equal 2 percent of total IPF PPS payments to ensure that IPFs treating unusually costly cases do not incur substantial losses and promote access to IPFs for patients who require expensive care. The fixed dollar loss threshold amount is published in the annual IPF PPS update notice or final rule. The specific regulations governing payments for outlier cases are located at 42 CFR 412.424(d) (3) (i).

Under 42 CFR §412.424 (d)(3)(i), for discharges in cost reporting periods beginning on or after January 1, 2005, high cost outlier payments may be reconciled at cost report settlement to account for differences between the cost-to-charge ratio (CCR) used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. Medicare

contractors will use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later, to obtain the applicable IPF CCR.

In addition, under 42 CFR § 412.424 (d)(3)(i),effective for discharges in cost reporting periods beginning on or after January 1, 2005, at the time of reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based on the regulations in 42 CFR §412.84 (m), except that CMS calculates a single overall (combined operating and capital) CCR for IPFs and national average IPF CCRs are used instead of statewide average CCRs.

Once the threshold amount is met, CMS will share a declining percentage of the losses for a high cost case. The risk-sharing percentages would be 80 percent of the difference between the cost for the case minus payment and the adjusted threshold amount for days 1 through 9 of the stay and 60 percent of the difference after the 9th day. Medicare contractors will determine the total outlier amount and divide by the number of days, then pay 80 percent for days 1-9 and 60 percent for days beyond that.

Outlier payments are not paid on interim bills, but they are calculated on a final discharge bill, a benefits exhaust bill, or if the patient falls below a covered level of care. For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/inpatientpsychfacilpps

Medicare contractors may choose to review outliers if data analysis deems it a priority.

The Pricer program makes all outlier determinations except for the medical review determinations.

190.7.2.1 - How to Calculate Outlier Payments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

1 - Calculate the Adjusted Fixed Dollar Loss Threshold Amount

- Multiply the threshold amount by the labor share and the area wage index;
- Multiply the threshold amount by the non-labor share and any applicable COLA (Alaska or Hawaii);
- Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural); and
- Add this amount to the sum of the Federal per diem payment and ECT payment to obtain the adjusted threshold amount.

2 - Calculate Eligible Outlier Costs

- Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.

- Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.

- Divide this amount by the length of stay to calculate the per diem outlier amount.

- For days 1 through 9, multiply this per diem outlier amount by 0.80. For day 10 and thereafter, multiply the per diem outlier amount by 0.60. The sum of these amounts is the total outlier payment.

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev. 4406, Issued: 10-01-19, Effective: 10-01-19, Implementation: 10-07-19)

For discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine the IPF's CCR. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals:

1) Identify total Medicare costs from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

Distinct Part Units

For IPFs that are distinct part psychiatric units:

1) Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101).

2) Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IPF unit that has the letter "S" or “M” in the third position of the Medicare provider number.

A. - Use of Alternative Data in Determining CCRs For IPFs Subject to the IPF PPS

Under 42 CFR 412.424(d)(3)(i,), for discharges in cost reporting periods beginning on or after January 1, 2005, CMS may direct Medicare contractors to use an alternative CCR to the CCRs from the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data.

B. - Request by the IPF for use of a Different CCR

For discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may request that an alternative CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request after evaluation by the Medicare contractor of the evidence presented by the IPF. Revised CCRs are applied prospectively to all IPF claims. Medicare contractors shall send notification to the CMS Central Office via the following address and e-mail address:

CMS
C/O Division of Chronic Care Management-IPF Outlier Team
7500 Security Blvd.
Mail Stop C5-05-27
Baltimore, MD. 21244
outliersipf@cms.hhs.gov

C. - Application of National Median CCRs for IPFs

For discharges in cost reporting periods occurring on or after January 1, 2005, the Medicare contractor may use the national CCRs for an IPF in one of the following circumstances:
1. New IPFs that have not yet submitted their first Medicare cost report.
2. IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

3. Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using the national median CCRs until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

NOTE: IPF PPS provides two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.

The policies in section E below can be applied as an alternative to the national median CCR. For those IPFs assigned the national median CCR, the CCR must be updated every October 1st based on the latest national median CCRs published in each year's IPF PPS notice or final rule until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D. - Notification to IPFs Under the IPF PPS of a Change in the CCR

The Medicare contractor shall notify an IPF whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to an IPF about a change to their CCR(s).

E. - Ongoing CCR Updates Using CCRs From Tentative Settlements For Entities Subject to the IPF PPS

For discharges beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentatively settled cost report (whichever is from the later period) to determine the IPF's CCR. Under the IPF PPS, Medicare contractors must update the IPFs CCR on the Provider Specific File to reflect the IPFs CCR from the most recent tentative settlements or final settled cost reports, (whichever is the later period). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

Subject to the approval of CMS, an IPF's CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all IPF PPS claims processed after the update.

F. - Alternative CCRs

Effective for discharges in cost reporting periods beginning on or after January 1, 2005, the CMS Central Office may direct Medicare contractors to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentatively settled cost report, if

CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office and CMS Central Office must approve any such request after evaluation by the Medicare contractor of the evidence presented by the IPF.

G. - IPF Mergers, Ownership Changes, and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IPF with the surviving provider number. If a new provider number (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement) is issued the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact CMS Central Office to seek guidance. Medicare contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Contractors shall contact the CMS regional and Central Office for further instructions. Contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

H. - Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

190.7.2.3 - Outlier Reconciliation

(Rev. 2242, Issued: 06-17-11, Effective: 07-01-11, Implementation: 07-01-11)

A. - General

Under §412.424 (d) (3) (i), for IPF services furnished during cost reporting periods beginning on or after January 1, 2005, IPF outlier payments may be reconciled upon cost report settlement to account for differences between the overall ancillary CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the service was furnished. IPF PPS outlier payments are reconciled if the CMS Central Office and Regional Office confirm that reconciliation is appropriate.

Effective for cost reporting periods beginning on or after April 1, 2011, subject to the approval of the CMS Central Office and Regional Office, the Medicare contractor shall reconcile an IPF's outlier claims at the time of cost report final settlement if they meet the following criteria:

1. The actual CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2. Total IPF outlier payments in that cost reporting period exceed $500,000.

To determine if an IPF meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR, and compute the actual overall ancillary CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for IPF outlier reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §190.7.2.5 of this chapter. The NPR cannot be issued nor can the cost report be finalized until IPF outlier reconciliation is complete. These IPF cost reports will remain open until their claims have been processed for IPF PPS outlier reconciliation.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect IPF PPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Central and Regional Offices for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §190.7.2.2(B) above.

Medicare contractors shall notify the CMS Central Office and Regional Office if a cost report was final settled and meets the qualifications for IPF PPS outlier reconciliation. Notification to the CMS Central Office shall be sent to the address and email address provided in §190.7.2.2 (B).

B. - Reconciling Outlier Payments IPFs

Beginning with the first cost reporting period starting on or after January 1, 2005, IPF outlier payments may be reconciled at cost report settlement to account for differences between the cost-to-charge ratio (CCR) used to pay the claim at its original submission by

the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. Effective for cost reporting periods beginning on or after April 1, 2011, if an IPF meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §190.7.2.5. The following examples demonstrate how to apply the criteria for reconciliation (as discussed in part A above):

EXAMPLE A:

Cost Reporting Period: 01/01/2010-12/31/2010

Operating CCR used to pay original claims submitted during cost reporting period: 0.40

(In this example, this CCR is from the tentatively or final settled 2007 cost report)

Final settled operating CCR from 01/01/2010-12/31/2010 cost report: 0.50

Total IPF PPS outlier payout in 01/01/2010-12/31/2010 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in IPF PPS outlier payments during that cost reporting period, the criteria are met for reconciliation, and therefore, the Medicare contractor notifies the Central Office and the Regional Office. The provider's IPF PPS outlier payments for this cost reporting period are reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period to calculate outlier payments, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. Example B below shows how to weight the CCRs. The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if IPF PPS outlier reconciliation is required. Total IPF PPS outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE B:

Cost reporting period: 01/01/2010-12/31/2010

Overall CCR used to pay original claims submitted during cost reporting period:

0.40 from 01/01/2010 to 03/31/2010 (This CCR could be from the tentatively settled 2006 cost report.)

0.50 from 04/01/2010 to 12/31/2010 (This CCR could be from the tentatively settled 2007 cost report.)

Final settled operating CCR from 01/01/2010 - 12/31/2010 cost report: 0.35

Total IPF outlier payout in 01/01/2010 -12/31/2010 cost reporting period: $600,000

Weighted average CCR: 0.476

CCR	DAYS	Weight	Weighted CCR
0.40	90	0.247 (90 Days / 365 Days)	(a) 0.099 = (0.40 * 0.247)
0.50	275	0.753 (275 Days / 365 Days)	(b) 0.377 = (0.50 * 0.753)
TOTAL	365	365	(a)+(b) = 0.476

The IPF meets the criteria for IPF PPS outlier reconciliation in this cost reporting period because the variance from the weighted average CCR at the time the claim was originally paid compared to the CCR from the cost report at the time of settlement is greater than 10 percentage points (from 0.476 to 0.35) and the provider received total IPF outlier payments greater than $500,000 for the entire cost reporting period.

Even if the IPF does not meet the criteria for reconciliation in §190.7.2.3, subject to approval of the CMS Central and Regional Offices, the Medicare contractor has the discretion to request that IPF PPS outlier payments in a cost reporting period be reconciled if the IPF's most recent cost and charge data indicate that the IPF PPS outlier payments to the IPF were significantly inaccurate. The Medicare contractor sends notification to the CMS Regional Office and Central Office via the address and email address provided in §190.7.2.2 (B). Upon approval of the CMS Central and Regional Office that IPF's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §190.7.2.3.

190.7.2.4 - Time Value of Money

(Rev. 2242, Issued: 06-17-11, Effective: 07-01-11, Implementation: 07-01-11)

Effective for discharges occurring on or after January 1, 2005, at the time of any reconciliation under §190.7.2, IPF outlier payment may be adjusted to account for the time value of money of any adjustments to IPF outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the IPF's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If an IPF's outlier payments have met the criteria for reconciliation, Medicare contractors will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula shall be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation. **NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

EXAMPLE C:
Cost reporting period: 01/01/2010 - 12/31/2010
Midpoint of cost reporting period: 07/01/2010
Date of reconciliation: 12/31/2010
Number of days from midpoint until date of reconciliation: 547

Rate from Social Security Web site: 4.625%

Overall ancillary CCR used to pay actual original claims in cost reporting period: 0.40
(This CCR could be from the tentatively settled 2006 or 2007 cost report.)

Final settled operating CCR from 01/01/2009 - 12/31/2009 cost report: 0.50

Total IPF outlier payout in 01/01/2009 - 12/31/2009 cost reporting period: $600,000

Because the CCR fluctuated from 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an IPF outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor follows the procedures in §190.7.2.4.

The reprocessing of claims indicates the revised IPF hospital outlier payments are $700,000.

Using the values above, the rate that is used for the time value of money is determined:
(4.625 / 365) * 548 = 6.9438%

Based on the claims reconciled, the provider is owed $100,000 ($700,000 - $600,000) for the reconciled amount and $6,943.80 for the time value of money.

190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IPF is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §190.7.2.2 (B), and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §190.7.2.2 (B)) that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - Type of Bill (TOB) equals 11X
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the IPF Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §190.7.2.4. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.09, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines please see § 3633.1 of the Provider Reimbursement Manual, Part II.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part II line 2, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part II of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 29 of Worksheet E-3, Part II.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPF PPS, Medicare contractors shall enter the original CCR in PSF field 25 - Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §190.7.2.2 (B) with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)

List of Data Elements for FISS Extract
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; ‘Y’ = MSP, ‘blank’ = no MSP
Reason Code

List of Data Elements for FISS Extract
HMO-IME Indicator
Filler

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev. 3575, Issued: 08-01-16, Effective: 10-01-16; Implementation: 10-03-16)

IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket and wage budget neutrality factor. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

In order to receive the payment, an IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

Effective with the implementation of ICD-10 the following ICD-10-PCS codes apply:

ICD-10-PCS Code and Description

GZB0ZZZ - Electroconvulsive Therapy, Unilateral-Single Seizure
GZB2ZZZ - Electroconvulsive Therapy, Bilateral-Single Seizure
GZB4ZZZ – Other Electroconvulsive Therapy

It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with 42 CFR 412.404(d)(3), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers.

190.7.4 - Stop Loss Provision (Transition Period Only)

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The IPF PPS includes a stop-loss provision during the 3-year transition. The purpose is to ensure each facility receives an average payment per case under the IPF PPS that is no less than 70 percent of its average payment under the TEFRA. It is calculated at cost report settlement. New providers are not eligible for stop-loss payments. See §190.9.1.

Example of stop-loss calculation in year 3 of the transition:

1. Enter Total (100%) TEFRA payments for cases during cost reporting period

2. Enter Total (100%) PPS payments for cases during cost reporting period

3. Multiply Step 1 by 0.70.

4. If Step 3 is greater than Step 2, subtract Step 2 from Step 3. Otherwise, enter 0.

5. Add Steps 2 and 4 to calculate total PPS payments.

6. Multiply Step 1 by 0.25 to calculate the TEFRA portion.

7. Multiply Step 5 by 0.75 to calculate the PPS portion.

8. Add Steps 6 and 7 to calculate the IPF's aggregate payments in the third year of the IPF PPS. Determine if this amount is at least 70 percent of what would have been paid under TEFRA, then pay the difference.

NOTE: Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. The CMS has previously stated that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition. Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39 percent.

190.8 - Transition (Phase-In Implementation)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.8.1 - Implementation Date for Provider

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS is phased-in over 3 years from the cost based reimbursement to the Federal prospective payment. All IPF providers must transition over the 3-year transition period. There is no election of 100 percent PPS in the first year.

During the transition period, payment is based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPF's TEFRA-based reimbursement rate for each case as follows:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

The 3-year transition period is separate from the annual update cycle of the IPF PPS. The transition is effective according to cost reporting periods, but the updates to the rates take effect July 1 of each year. For more detailed information regarding the annual update cycle, refer to §190.4.3-Annual Update.

Although the IPF PPS is effective January 1, 2005, an individual IPF's PPS transition year start date is the first day of the first cost reporting period that begins on or after that date. An IPF may begin the IPF PPS as early as January 1, 2005, or as late as December 31, 2005, should a cost reporting period begin on that date.

The IPF PPS applies to claims for discharges occurring in the IPF's first cost reporting period beginning on or after January 1, 2005. Where the IPF has already billed interim claims for an inpatient that has benefit days remaining after the PPS implementation date, the provider must submit a cancel bill and re-bill under the IPF PPS so that payment for the entire stay is made under the IPF PPS.

If the provider ever had a TEFRA limit, the IPF is not a new provider and therefore will receive the blended payment. This includes those providers that previously closed their psychiatric units and then re-opened the psychiatric units. If the provider had a TEFRA limit established, that TEFRA limit is updated using the rate of increase percentages in 42 CFR 413.40.

For cost reporting periods beginning in FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket increase percentage minus a factor based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recently available cost reporting period.

To update the TEFRA limit for IPFs that were closed during FY 1999 through FY 2002 and then re-opened (including CAHs that were statutorily precluded from having a distinct part unit), the rate-of-increase for these years would be the full market basket up to the cap on the target amounts.

190.9 - Definition of New IPF Providers Versus TEFRA Providers

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.9.1 - New Providers Defined

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A new IPF provider is one that meets the definition of an IPF in 42 CFR 412.402, and under present or previous ownership or both, has not received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005. To be a new provider, the first cost reporting period as a psychiatric hospital, a distinct part unit in an acute care hospital or a CAH must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.

Change of ownership has no impact on whether an IPF is considered a new IPF provider.

190.10 - Claims Processing Requirements Under IPF PPS

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.10.1 - General Rules

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Medicare provider number ranges for IPFs are from xx-4000 - xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must correctly code diagnoses for the principal diagnosis, and up to twenty four additional diagnoses, if applicable;
- The IPF must correctly code one principal procedure and up to twenty four additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and
- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in Chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date (or effective December 3, 2007, benefits exhaust date, if present) on the claim will determine the DRG/MS-DRG assignment.

190.10.2 - Billing Period

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

When the patient has Medicare benefits, IPF providers will submit one admit through discharge claim for the stay upon discharge. IPFs may interim bill in 60-day intervals following the instructions in chapter 1, §50.2 of this manual should the patient's stay be exceptionally long. Final PPS payment is based upon the date of physical discharge or death, or the date benefits exhausted (effective December 3, 2007).

IPFs can submit adjustment claims, but late charge claims will not be allowed, e.g., the adjustment claim must include all charges and services and must replace the earlier claim(s) instead of including only the additional charges and services.

In situations when a patient falls below a skilled level of care, IPFs should submit a 112 TOB with both an Occurrence Code 22 (Date active care ended) and patient status code 30 (Still a patient). IPFs should then continue to submit subsequent interim 117 TOBs, as appropriate, with the patient status code 30 and the correct Occurrence Span Codes that identify payment liability (codes 76 or 77).

Effective December 3, 2007, once the patient's Medicare benefit's exhaust, the IPF is allowed to submit no-pay bills (TOB 110), with a Patient Status Code of 30 every 60 days, until the patient is physically discharged or dies. The last bill shall contain a discharge patient status code. IPFs no longer need to continually adjust claims once benefits exhaust.

190.10.3 - Patient Status Coding

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

All patient status (i.e., discharge disposition) codes for 11X TOB are valid, but there are no special payment policies related to transfer codes; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with Condition Code 40) are applicable under IPF PPS.

190.10.4 - Reporting ECT Treatments

(Rev. 4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

IPFs must report on their claims under Revenue Code 0901: the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Providers will code ICD-9-CM procedure code 94.27 if ICD-9-CM is applicable, or, effective with the implementation of ICD-10, providers will code the ICD-10-PCS codes listed below in the procedure code field, and for the procedure date will use the date of the last ECT treatment the patient received during their IPF stay.

ICD-10-PCS Code and Description

GZB0ZZZ - Electroconvulsive Therapy, Unilateral-Single Seizure

GZB2ZZZ - Electroconvulsive Therapy, Bilateral-Single Seizure
GZB4ZZZ - Other Electroconvulsive Therapy

190.10.5 - Outpatient Services Treated as Inpatient Services
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs are subject to the 1-day payment window for outpatient bundling rules. Refer to chapter 3, §40.3 of this manual for more information on bundling rules.

190.10.6 - Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The payer at the time of the patient's admission to an IPF is responsible for the cost of the entire stay. This could occur for patients who move from traditional Medicare to a Medicare Advantage plan or vice versa.

190.10.7 - Billing for Interrupted Stays
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs shall bill for the interrupted stay using Occurrence Span Code 74. The Occurrence Span Code FROM date equals the day of discharge for the IPF and the THROUGH date is the last day the patient was not present in the IPF at midnight. For example, the patient leaves the IPF on 1/1 and returns to the IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 - 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed. The accommodation Revenue Code 018X (RT 50, field 5), (SV 201), (leave of absence) will continue to be used in the current manner in terms of Occurrence Span Code 74 (RT 40, field 22 - 27) and date range.

190.10.8 - Grace Days
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no grace days allowed under IPF PPS, therefore the date the beneficiary is notified of the provider's intent to bill (Occurrence Code 31) is the last covered day for that patient.

190.10.9 - Billing Stays Prior to and Discharge After PPS Implementation Date
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under IPF PPS, payment to the facility is based on IPF PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (see chapter 1, §50.2 of this manual). If the facility

submitted multiple interim bills, the facility will need to submit cancels for all bills and then re-bill once the cancels are accepted.

Exceptions:

If the beneficiary's benefits were exhausted or the beneficiary is in a non-covered level of care prior to implementation of IPF PPS, then IPF PPS is not applicable and the IPF will continue to submit no-pay bills (TOB 110) to Medicare.

190.10.10 - Billing Ancillary Services Under IPF PPS

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no special rules for billing IPF inpatient ancillary services.

190.10.11 - Covered Costs Not Included in IPF PPS Amount

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The following covered services are not included in the IPF PPS discharge payment amount:

- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS.

- DGME and bad debts.

190.10.12 - Same Day Transfer Claims

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A same day transfer occurs when a patient is admitted to an IPF and is subsequently transferred for acute care (or another type of inpatient facility care) on the same day. If the patient is admitted to an IPF with the expectation that the patient will remain overnight, but is discharged before midnight, the day is counted as a full day for the cost report, but is not counted as a Medicare covered day for purposes of charging the beneficiary utilization.

IPFs should show the same day for admission and discharge, and report Condition Code 40 (Same Day Transfer).

If the patient is admitted to an IPF and discharged (not transferred to another inpatient setting) the same day before midnight, the day is counted as a full day for the cost report, and is counted as a Medicare covered day for purposes of charging the beneficiary utilization. IPFs do not report Condition Code 40 on this case.

The purpose for the variance in coding is to charge the beneficiary only 1 day utilization where two facilities are billing. Payment will be made for 1 day.

190.10.13 - Remittance Advice - Reserved
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Not yet available.

190.10.14 - Medicare Summary Notices and Explanation of Medicare Benefits
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Existing notices for inpatient hospital PPS are used.

190.11 - Benefit Application and Limits-190 Days
(Rev. 4104, Issued: 08-03-18, Effective: 10-01-18, Implementation: 10-01-18)

The psychiatric benefit lifetime maximum of 190 days of inpatient care applies to Medicare participating psychiatric hospitals per 42 CFR 409.62. The 190-day lifetime limitation does not apply to inpatient psychiatric care provided in certified psychiatric units of an acute care hospital or critical access hospital. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. This limitation does not apply to inpatient psychiatric services furnished in a non-psychiatric hospital. This limitation does not apply to inpatient psychiatric services furnished in a hospital, a CAH or distinct part psychiatric unit. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

The Benefit Period provisions described in Medicare Publication 100-01, Medicare General Information, Eligibility, and Entitlement, chapter 3, §§10.4-10.4.4 are applicable to inpatients in either a Medicare participating psychiatric hospital or a certified psychiatric unit of an acute care hospital or critical access hospital.

The CWF keeps track of days paid for inpatient psychiatric services and informs the Medicare contractor on claims where the 190-day limit is reached.

For a more detailed description see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §30.C. and chapter 4, §50 for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services. For details concerning the pre-entitlement inpatient psychiatric benefit reduction provision see Pub. 100-02, Medicare Benefit Policy Manual, chapter 4, §§10 - 50.

190.12 - Beneficiary Liability
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system. An IPF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

An IPF receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least 1 covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under 42 CFR 409.82, 42 CFR 409.83, and 42 CFR 409.87 and for items or services as specified under 42 CFR 489.30.

For more detailed information regarding lifetime reserve days, refer to Pub. 100-02 Medicare Benefit Policy Manual, chapter 5.

190.12.1 - Benefits Exhaust

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Effective December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust and the date benefits exhaust (if present) will substitute for the 'actual' discharge date. The claim is paid based on the benefits exhaust date if present rather than the discharge date. The Pricer version used to price claims for the discharge is when the services actually were provided (i.e., when the Medicare beneficiary has Medicare benefits). No pay/110 TOBs are allowed instead of continually adjusting the claims (117 TOB) until actual discharge occurs once benefits exhaust.

Under TEFRA, the PS&R report used the benefits exhaust date as the discharge date (if present). This changed when the IPF PPS was implemented, and the 'actual' discharge date was used. The days stay with the year they occurred, making it easier for the PS&R report (especially during the blend period) to settle the cost report. This means that:

1. Claims will now be settled on the appropriate cost report;

2. The appropriate PPS-TEFRA blend percentage will be paid;

3. Patients with long lengths of stay will be counted on the correct PS&R report;

4. The PRICER version used will be the one in effect at the time the services were provided (i.e., when the Medicare beneficiary actually has Medicare benefits).

190.13 - Periodic Interim Payments (PIP)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Medicare contractors shall pay PIP for providers who send a request to their Medicare contractor and qualify. Outlier payments, teaching adjustment, and ECT add-on payments

are not included in the PIP payment amount but are paid on the discharge claim for ECT, and on a discharge, benefits exhaust, or last day of a Medicare covered level of care claim, for the teaching adjustment and outlier payment.

190.14 - Intermediary Benefit Payment Report (IBPR)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IBPR report has been changed to reflect the payments for IPFs going to PPS psychiatric hospitals and units.

190.15 - Monitoring Implementation of IPF PPS Through Pulse

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The FISS 620A and 620B reports will be modified to add an additional row for IPF monitoring. The report will be modified to include a separate reporting line titled "IPF PPS." This entry will appear immediately below "IPF PPS" and report the total claim count and total reimbursement amount. IPF PPS totals will include all providers with the last four digits of the provider numbers in range 4000 - 4499, xx-Sxxx, and xx-Mxxx.

190.16 - IPF PPS System Edits

(Rev. 2157, Issued: 02-11-11, Effective: 04-01-11, Implementation: 04-04-11)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines.

- The length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.

- Value Code 75 is allowed from contractor entry and not allowed from Provider entry. Also, Providers are not allowed to alter this information.

- The ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit with the application of the correct Point of Origin code "D" on the IPF PPS claim.

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

CWF shall ensure that:

- Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the same IPF within 3 days).

- Value Code 75 is present on claims when there is an interrupted stay resulting from a discharge at another IPF (the beneficiary has returned to the different IPF within 3 days).

190.17 - IPF PPS PRICER Software

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

CMS has developed an IPF PRICER program that calculates the Medicare payment rate. PRICER software will be electronically supplied to the Standard Systems. A Personal Computer (PC) version of this PRICER will be available on the CMS Web site in the future at http://www.cms.hhs.gov/PCPricer.

PRICER will incorporate the 3-year phase-in period for all current IPFs. New IPFs will be paid completely under the new IPF PPS (i.e., there is no transition for new IPFs).

190.17.1 - Inputs/Outputs to PRICER

(Rev. 10222, Issued: 07-14-20, Effective: 10-01-20, Implementation: 10-05-20)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator
9	Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.
12	Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)
17	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
18	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)

Data Element	Title
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)
23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)
38	Special Wage Index
48	New Hospital
63	*Supplemental Wage Index*
64	*Supplemental Wage Index Indicator*

Bill Data

National Provider Identifier	Covered Charges
OSCAR Number	Discharge Date (or benefits exhaust date if present)
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number
	Indicator for Value Code75 to apply variable per diem adjustment to this bill.

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment
DRG/MS-DRG Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
National Non-Labor Rate
Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate

Per Diem Adjusted Payment	Standardized Factor
Facility Adjusted Payment	Labor Share
Age Adjusted Payment	Non-Labor Share
Rural Adjusted Payment	COLA
Teaching Adjusted Payment	Day of Stay Adjustment
ED Adjusted Payment	Age Adjustment
ECT Adjusted Payment	Comorbidity Adjustment
Return Code	DRG Adjustment
MSA/CBSA	Rural Adjustment
Wage Index	ECT Adjustment
National Labor Rate	Blend Year Calculation Version

200 - Electronic Health Record (EHR) Incentive Payments

(Rev. 2066, Issued: 10-15-10, Effective: 10-01-10, Implementation: 01-03-11)

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5) provides incentive payments for acute care hospitals (subsection (d) hospitals) and critical access hospitals (CAHs) who are meaningful users of certified electronic health records (EHR) technology.

200.1 - Payment Calculation

(Rev. 2066, Issued: 10-15-10, Effective: 10-01-10, Implementation: 01-03-11)

A - Incentive Payment Calculation for Subsection (d) Hospitals

[Initial Amount] x [Medicare Share] x [Transition Factor]

- **Initial Amount** equals $2,000,000 + [$200 per discharge for the 1,150th - 23,000th discharge]
- **Medicare Share** equals Medicare/(Total*Charges), whereas:
  - **Medicare** equals [number of Inpatient Bed Days for Part A Beneficiaries] plus [number of Inpatient Bed Days for MA Beneficiaries]
  - **Total** equals [number of Total Inpatient Bed Days]
  - **Charges** equals [Total Charges minus Charges for Charity Care*] divided by [Total Charges]
- **Transition Factor**

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	**2012**	**2013**	**2014**	**2015**
2011	1.00				
2012	0.75	1.00			
2013	0.50	0.75	1.00		
2014	0.25	0.50	0.75	0.75	
2015		0.25	0.50	0.50	0.50
2016			0.25	0.25	0.25

B - Incentive Payment Calculation for Critical Access Hospitals (CAHs)

CAH Reasonable Cost x Medicare Share*

* See Medicare Share computation in sub-section A above.

200.2 - Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

(Rev. 2066, Issued: 10-15-10, Effective: 10-01-10, Implementation: 01-03-11)

Acute care hospitals already submit informational only bills for purposes of including Part C days in the Disproportionate Share (DSH) calculations, as explained in Section 20.3 above. However, Maryland waiver hospitals and CAHs do not currently submit informational only bills. In order for CMS to capture Part C days for purposes of calculating EHR payments, Maryland waiver hospitals and CAHs must submit informational only claims to Medicare, effective for discharges October 1, 2010. Informational only claims are claims billed for patients enrolled in a Medicare Advantage (MA) Plan and contain a condition the following elements:

- Covered 11X TOB (not 110)
- Condition Code 04
- Medicare is the primary payer
- There is no MSP
- Beneficiary‘s Medicare HICN
- All other required claim elements

250.18 Incomplete Colonoscopies (Codes 44388, 45378, G0105 and G0121)

(Rev. 4153, Issued: 10-26-18, Effective: 04-01-19, Implementation: 04-01-19)

An incomplete colonoscopy, e.g., the inability to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, is billed and paid using colonoscopy through stoma code 44388, colonoscopy code 45378, and screening colonoscopy codes G0105 and G0121 with modifier "-53." (Code 44388 is valid with modifier 53 beginning January 1, 2016.) The Medicare physician fee schedule database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. An incomplete colonoscopy performed prior to January 1, 2016, is paid at the same rate as a sigmoidoscopy. Beginning January 1, 2016, Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

As such, instruct CAHs that elect Method II payment to use modifier "-53" to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X).

CAH Method II shall be consistent with the guidelines outlined in PUB. 100-04, chapter 12, section 30.1 and chapter 18, section 60.2.

Addendum A - Provider Specific File

(Rev. 10371, Issued: 09-24-20, Effective: 10-01-20, Implementation: 10-05-20 - Analysis and Design; 01-04-21 - Design, Coding and Testing)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

Data Element	File Position	Format	Title	Description
2	11-16	X(6)	Provider Oscar No.	Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:

Provider #	**Provider Type**
00-08	Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (**NOTE:** SB = swing bed):

Special Unit	**Prov. Type**
M - Psych unit in CAH	49
R - Rehab unit in CAH	50
S - Psych Unit	49
T - Rehab Unit	50
U - SB for short-term hosp.	51
W - SB for LTCH	52
Y - SB for Rehab	53
Z - SB for CAHs	54

3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a “Y” or “N.” Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts

Data Element	File Position	Format	Title	Description
				(Provider type “06” is effective until July 1, 2006. At that point, provider type “06” will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers

Data Element	File Position	Format	Title	Description
				43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.

Data Element	File Position	Format	Title	Description
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.

Data Element	File Position	Format	Title	Description
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent

Data Element	File Position	Format	Title	Description
				IRF PPS: All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 Federal % 20 Facility% 80 2 40 60 3 60 40 4 80 20 5 100 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 Federal % 25 Facility% 75 2 50 50 3 75 25 4 100 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that

Data Element	File Position	Format	Title	Description
				effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)

Data Element	File Position	Format	Title	Description
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

Data Element	File Position	Format	Title	Description
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will

Data Element	File Position	Format	Title	Description
				automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a “1” or “2.”
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.

Data Element	File Position	Format	Title	Description
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.

Data Element	File Position	Format	Title	Description
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter “0” if not participating in Hospital Readmissions Reduction program. Enter

Data Element	File Position	Format	Title	Description
				"1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.

Data Element	File Position	Format	Title	Description
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index 2= current year IPPS-comparable wage index (LTCHs only)* 3=Future use 4=Future use Enter blank if it does not apply. **Note:** For LTCHs, a value of '2' is the current year's IPPS-comparable wage index value that is used for short-stay outlier and site neutral payment rate payments.
65	277-285	9(7)V99	Pass Through Amount for Allogeneic Stem Cell Acquisition	Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell transplants. Zero-fill if this does not apply.
66	286-310	X(25)	Filler	

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10371CP	09/24/2020	Change to the Payment of Allogeneic Stem Cell Acquisition Services	10/05/2020	11729
R10321CP	08/28/2020	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021	10/05/2020	11858
R10312CP	08/21/2020	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2021	10/05/2020	11949
R10222CP	07/14/2020	Updates in the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific Files (PSF)	10/05/2020	11797
R10140CP	05/15/2020	Updates in the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific Files (PSF)- Rescinded and replaced by Transmittal 10222	10/05/2020	11797
R10121CP	05/08/2020	Updates in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	10/05/2020	11707
	07/10/2020	Change to the Payment of Allogeneic Stem Cell Acquisition Services - Rescinded and replaced by Transmittal 10371	10/05/2020	11729
R10210CP	07/10/2020	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 20 and 90.6	08/10/2020	11829
R10002CP	03/20/2020	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 90.4.2	04/20/2020	11687
R4406CP	10/01/2019	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020	10/07/2019	11420
R4390CP	09/06/2019	Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes	10/07/2019	11361
R4357CP	08/09/2019	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020- Rescinded and replaced by Transmittal 4406	10/07/2019	11420

Rev #	Issue Date	Subject	Impl Date	CR#
R4353CP	08/02/2019	Inpatien1t Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020	10/07/2019	11345
R4337CP	07/18/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model	07/01/2019	10971
R4308CP	05/16/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model - Rescinded and replaced by Transmittal 4337	07/01/2019	10971
R4257CP	03/14/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model- Rescinded and replaced by Transmittal 4308	07/01/2019	10971
R4230CP	02/01/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model	07/01/2019	10971
R4271CP	03/29/2019	Update to the Internet-Only-Manual (IOM) Publication (Pub.) 100-04, Chapters 1 and 3	04/29/2019	11188
R4157CP	11/02/2018	Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions and Shared Systems Changes	04/01/2019	10962
R4166CP	11/09/2018	Revisions to Medicare Claims Processing Manual Reference to Burn Medicare Severity-Diagnostic Related Groups (MS-DRGs) for Transfer Policy	12/11/2018	11020
R4153CP	10/26/2018	Incomplete Colonoscopies Billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers	04/01/2019	10937
R4104CP	08/03/2018	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2019	10/01/2018	10880
R4144CP	10/04/2018	Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes- No Longer Sensitive	10/01/2018	10869
	09/07/2018	Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes **SENSITIVE/**	10/01/2018	10869

Rev #	Issue Date	Subject	Impl Date	CR#
		CONTROVERSIAL DO NOT POST- Rescinded and replaced by Transmittal 4144		
R4101CP	08/03/2018	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2019	10/01/2018	10826
R4046CP	05/10/2018	Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Extensions per the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act Included in the Bipartisan Budget Act of 2018	04/02/2018	10547
R4038CP	04/27/2018	Notification of Change in Instructions for Handling IRF Active Provider List	04/23/2018	10459
R4008CP	03/23/2018	Notification of Change in Instructions for Handling IRF Active Provider List – Rescinded and replaced by Transmittal 4038	04/23/2018	10459
R3836CP	08/18/2017	Home Health Value-Based Purchasing Implementation	11/21/2017	9939
R3849CP	08/25/2017	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2018	10/02/2017	10125
R3826CP	08/04/2017	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2018	10/02/2017	10214
R3795CP	06/16/2017	Updates in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	10/02/2017	10165
R3779CP	05/24/2017	Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42	04/03/2017	9818
R3750CP	04/19/2017	New Fields in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	07/03/2017	9926
R3718CP	02/14/2017	Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42-- Rescinded and replaced by Transmittal 3779	04/03/2017	9818

Rev #	Issue Date	Subject	Impl Date	CR#
R3712CP	02/03/2017	New Fields in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	07/03/2017	9926
R3635CP	10/28/2016	Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42 – Rescinded and replaced by Transmittal 3718	04/03/2017	9818
R3590CP	08/01/2016	Changes to the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific File (PSF) for Low-Volume Hospital Payment Adjustment Factor and New Inpatient Prospective Payment System (IPPS) Pricer Output Field for Islet Isolation Add-on Payment	10/03/2016	9570
R3576CP	08/05/2016	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2017	10/03/2016	9669
R3575CP	08/01/2016	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2017	10/03/2016	9732
R3571CP	07/29/2016	New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services	01/03/2017	9674
R3556CP	07/01/2016	Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, Sickle Cell Disease, and Myelodysplastic Syndromes	10/03/2016	9620
R3511CP	04/29/2016	Changes to the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific File (PSF) for Low-Volume Hospital Payment Adjustment Factor and New Inpatient Prospective Payment System (IPPS) Pricer Output Field for Islet Isolation Add-on Payment – Rescinded and replaced by Transmittal 3590	10/03/2016	9570
R3509CP	04/29/2016	Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, Sickle Cell Disease, and Myelodysplastic Syndromes - Rescinded and replaced by Transmittal 3556	10/03/2016	9620
R3504CP	04/28/2016	Revision of the Method to Calculate the Length of Stay (LOS) Edit for Continuous Invasive Mechanical Ventilation for Greater than 96 Consecutive Hours	10/03/2016	9559
R3481CP	03/18/2016	Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages	06/20/2016	9562

Rev #	Issue Date	Subject	Impl Date	CR#
R3452CP	02/04/2016	Additional Fields Added to the Outlier Reconciliation Lump Sum Utility	07/05/2016	9472
R3445CP	01/29/2016	Off-Cycle Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2016 Pricer	04/04/2016	9527
R3431CP	12/29/2015	Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes	10/05/2015	9253
R3388CP	10/30/2015	Manual Updates to Clarify IRF Claims Processing	12/02/2015	9362
R3373CP	10/14/2015	Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes – Rescinded and replaced by Transmittal 3431	10/05/2015	9253
R3360CP	09/24/2015	Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes – Rescinded and replaced by Transmittal 3373	10/05/2015	9253
R3357CP	09/18/2015	Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes – Rescinded and Replaced by Transmittal 3360	10/05/2015	9253
R3332CP	08/21/2015	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2016	10/05/2015	9305
R3331CP	08/21/2015	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2016	10/05/2015	9236
R3199CP	02/20/2015	Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims	04/21/2015	8940
R3082CP	09/30/2014	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2015	10/06/2014	8889
R3075CP	09/24/2014	Date Correction to Diagnosis Code Reporting on Religious Nonmedical Health Care Institution (RNHCI) Claims	11/12/2014	8857
R3054CP	08/29/2014	Ventricular Assist Devices for Bridge-to-Transplant and Destination Therapy	09/30/2014	8803

Rev #	Issue Date	Subject	Impl Date	CR#
R3039CP	08/22/2014	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2015	10/06/2014	8788
R3034CP	08/22/2014	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2015 – Rescinded and replaced by Transmittal 3082	10/06/2014	8889
R3030CP	08/22/2014	Update to Pub. 100-04, Chapter 03 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	09/23/2014	8679
R3017CP	08/08/2014	Date Correction to Diagnosis Code Reporting on Religious Nonmedical Health Care Institution (RNHCI) Claims – Rescinded and replaced by Transmittal 3075	11/12/2014	8857
R2933CP	04/17/2014	Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Addition of New Fields and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output	07/07/2014	8546
R2930CP	04/11/2014	Denial Letters for Religious Nonmedical Health Care Institution Services Not Covered by Medicare	07/14/2014	8559
R2870CP	02/05/2014	Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Addition of New Fields and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output – Rescinded and replaced by Transmittal 2933	07/07/2014	8546
R2819CP	11/19/2013	Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes	10/07/2013	8421
R2778CP	08/30/2013	Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes – Rescinded and replaced by Transmittal 2819	10/07/2013	8421
R2769CP	08/16/2013	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2014	10/07/2013	8326

Rev #	Issue Date	Subject	Impl Date	CR#
R2768CP	08/16/2013	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2014	10/07/2013	8395
R2765CP	08/16/2013	Diagnosis Code Reporting on Religious Nonmedical Health Care Institution Claims	01/06/2014	8350
R2722CP	06/11/2013	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims	01/29/2012	8103
R2719CP	06/07/2013	Pass-through Payments for Certified Registered Nurse Anesthetist Anesthesia Services and Related Care	09/09/2013	7896
R2673CP	03/14/2013	Manual Updates to Clarify IRF Claims Processing	04/22/2013	8127
R2674CP	03/14/2013	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims – Rescinded and replaced by Transmittal 2722	01/29/2013	8103
R2654CP	02/08/2013	Updates to Claims Processing Instructions Regarding Religious Nonmedical Health Care Institutions (RNHCI)	05/09/2013	8186
R2638CP	01/18/2013	Manual Updates to Clarify IRF Claims Processing – Rescinded and replaced by Transmittal 2673	04/22/2013	8127
R2627CP	01/04/2013	Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes	10/01/2012	8041
R2625CP	12/28/2012	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims – Rescinded and replaced by Transmittal 2674	01/29/2012	8103
R2576CP	11/01/2012	Affordable Care Act (ACA) Section 3025 Expansion of a Field in the Inpatient Provider Specific File) PSF)	04/01/2013	8067
R2539CP	08/31/2012	Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes – Rescinded and replaced by Transmittal 2627	10/01/2012	8041
R2520CP	08/17/2012	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2013	10/01/2012	8000

Rev #	Issue Date	Subject	Impl Date	CR#
R2518CP	08/10/2012	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2013	10/01/2012	7901
R2513CP	08/03/2012	Liver Transplantation for Patients with Malignancies	09/04/2012	7908
R2489CP	06/22/2012	Attending Provider Identifiers on Religious Nonmedical Health Care Institution Claims	09/24/2012	7862
R2447CP	04/26/2012	Additional Fields Added to the Outlier Reconciliation Lump Sum Utility	10/01/2012	7789
R2397CP	01/26/2012	Update to Abortion Condition Codes Associated With Reason Code 32809	07/02/2012	7687
R2393CP	01/25/2012	Inpatient Rehabilitation Facility (IRF) No-Pay Billing for Medicare Advantage (MA) Patients Update	07/02/2012	7674
R2388CP	01/20/2012	Update to Pub. 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing	04/22/2012	7706
R2367CP	12/09/2011	Verification of Status for all Hospitals Qualifying for Disproportionate Share Hospital (DSH) Payments Under 42CFR Section 412.106(c)(2), also known as the “Pickle Amendment” – Rescinded and replaced by Transmittal 2367	10/05/2009	6564
R2334CP	10/28/2011	Billing for Donor Post-Kidney Transplant Complication Services	04/02/2011	7523
R2332CP	10/28/2011	Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Patients	04/02/2011	7553
R2301CP	09/13/2011	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2012	10/03/2011	7510
R2285CP	08/26/2011	Attending Physician Identifiers on Religious Nonmedical Health Care Institution Claims	11/28/2011	7542
R2275CP	08/12/2011	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2012 – Rescinded and replaced by Transmittal 2301	10/03/2011	7510
R2242CP	6/17/2011	Revision to Formula to Compute the Time Value of Money under the Inpatient Prospective Payment System (IPPS), Outpatient Prospective	07/01/2011	7464

Rev #	Issue Date	Subject	Impl Date	CR#
		Payment System (OPPS), Inpatient Rehabilitation Facility (IRF PPS), Inpatient Psychiatric Facility (IPF PPS) and Long Term Care Hospital (LTCH PPS)		
R2222CP	05/20/2011	Pass-through Payment for Certified Registered Nurse Anesthetist Services	10/03/2011	7379
R2220CP	05/20/2011	Update - Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2012	07/05/2011	7367
R2193CP	04/22/2011	Updates to Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing	07/23/2011	7385
R2157CP	02/11/2011	Implementation of Edits for the Emergency Department (ED) Adjustment Policy Under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	04/04/2011	7072
R2117CP	12/10/2010	Revisions to the Medicare Code Editor (MCE) and Integrated Outpatient Code Editor(IOCE) Reporting Requirements	01/12/2011	7246
R2111CP	12/03/2010	Outlier Reconciliation and other Outlier Manual Updates for the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Rehabilitation Facility (IRF) PPS, Inpatient Psychiatric Facility (IPF) PPS and Long Term Care Hospital (LTCH) PPS	04/04/2011	7192
R2089CP	11/12/2010	Implementation of Edits for the Emergency Department (ED) Adjustment Policy Under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) – Rescinded and replaced by Transmittal 2157	04/04/2011	7072
R2083CP	10/29/2010	Implementation of the Interrupted Stay Policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	01/03/2011	7044
R2066CP	10/15/2010	Submission of Informational Only Claims by Maryland Waiver Hospitals and Critical Access Hospitals (CAHs) for Electronic Health Records (EHR) Purposes	01/03/2011	7172
R2062CP	10/08/2010	Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for Myelodysplastic Syndrome (MDS)	11/10/2010	7137

Rev #	Issue Date	Subject	Impl Date	CR#
R2060CP	10/01/2010	Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS and Inpatient Psychiatric Facility (IPF) PPS Changes	10/04/2010	7134
R2057CP	09/17/2010	Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS and Inpatient Psychiatric Facility (IPF) PPS Changes – Rescinded and replaced by Transmittal 2060	10/04/2010	7134
R2026CP	08/13/2010	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2011	10/04/2010	7076
R2028CP	08/13/2010	5010 Implementation--Processing Additional International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) Diagnosis and Procedure Codes in Pricer, Grouper, and the Medicare Code Editor (MCE)	01/03/2011	7004
R2016CP	07/30/2010	5010 Implementation--Processing Additional International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) Diagnosis and Procedure Codes in Pricer, Grouper, and the Medicare Code Editor (MCE) - Rescinded and replaced by Transmittal 2028	01/03/2011	7004
R2011CP	07/30/2010	Revised Instructions for Reporting Assessment Dates under the Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and Swing Bed (SB) Prospective Payment Systems (PPS)	01/03/2011	7019
R2009CP	07/29/2010	Implementation of the Interrupted Stay Policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) – Rescinded and replaced by Transmittal 2083	01/03/2011	7044
R2008CP	07/30/2010	Common Working File (CWF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased	01/03/2011	6978
R1981CP	-6/04/2010	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2011	07/06/2010	6986
R1895CP	01/15/2010	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims	04/05/2010	6547

Rev #	Issue Date	Subject	Impl Date	CR#
R1890CP	01/08/2010	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims – Rescinded and replaced by Transmittal 1895	04/05/2010	6547
R1882CP	12/21/2009	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/04/2010	6751
R1871CP	12/11/2009	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Rescinded and replaced by Transmittal 1882	01/04/2010	6751
R1838CP	10/28/2009	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims – Rescinded and replaced by Transmittal 1890	04/05/2010	6547
R1828CP	10/09/2009	Verification of Status for all Hospitals Qualifying for Disproportionate Share Hospital (DSH) Payments Under 42CFR Section 412.106(c)(2), also known as the “Pickle Amendment” – Rescinded and replaced by Transmittal 2367	10/05/2009	6564
R1816CP	09/17/2009	Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes	10/05/2009	6634
R1815CP	09/09/2009	Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes - Rescinded and replaced by Transmittal 1816	10/05/2009	6634
R1811CP	09/04/2009	Verification of Status for all Hospitals Qualifying for Disproportionate Share Hospital (DSH) Payments Under 42CFR Section 412.106(c)(2), also known as the “Pickle Amendment” – Rescinded and replaced by Transmittal 1828	10/05/2009	6564
R1808CP	08/28/2009	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2010	10/05/2009	6607
R1780CP	07/24/2009	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2010	07/06/2009	6461

Rev #	Issue Date	Subject	Impl Date	CR#
R1741CP	05/22/2009	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2010 – Rescinded and replaced by Transmittal 1780	07/06/2009	6461
R1702CP	03/13/2009	April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)	04/06/2009	6416
R1695CP	03/06/2009	Providers Submitting Information Regarding Medicare Beneficiaries Entitled to Medicare Advantage (MA) for Fiscal Year 2006 for the Medicare/Supplemental Security Income (SSI) Fraction	07/06/2009	6329
R1677CP	02/13/2009	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States. Rescinds and fully replaces CR 6217.	03/13/2009	6327
R1649CP	12/18/2009	Procedures for Paying Claims Without Passing Through the Integrated Outpatient Code Editor (OCE) or Medicare Code Editor (MCE)	11/25/2008	6252
R1619CP	10/24/2008	Procedures for Paying Claims Without Passing Through the Integrated Outpatient Code Editor (OCE) or Medicare Code Editor (MCE) - Rescinded and replaced by Transmittal 1649	11/25/2008	6252
R1612CP	10/03/2008	Revision of Interim Payment Methodology for Religious Nonmedical Health Care Institution (RNHCI), Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel, Claims Not Billed to the RNHCI Specialty Contractor, and Statutory End of Coverage for RNHCI Items and Services Furnished in the Home	01/05/2009	5383
R1609CP	10/03/2008	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States – Rescinded and replaced by CR 6327, Transmittal 1677	01/05/2009	6217
R1592CP	09/10/2008	Artificial Hearts	12/01/2008	6185
R1585CP	09/05/2008	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2009	10/06/2008	6166
R1583CP	08/29/2008	Artificial Hearts - Replaced by Transmittal 1592	10/06/2008	6185
R1571CP	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849

Rev #	Issue Date	Subject	Impl Date	CR#
R1547CP	07/03/2008	Update Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Rate Year 2009	07/07/2008	6114
R1543CP	06/27/2008	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2009	07/07/2008	6077
R1510CP	05/20/2008	Revision to the Inpatient Prospective Payment System (IPPS) Post Acute Transfer Policy for Discharges/Transfers to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care - Rescinded and Not Replaced	10/06/2008	6012
R1509CP	05/16/2008	Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit	10/06/2008	5860
R1498CP	05/02/2008	Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit – Replaced by Transmittal 1509	10/06/2008	5860
R1495CP	05/02/2008	Billing Blood and Blood Products	10/06/2008	5867
R1479CP	03/14/2008	April 2008 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer Changes	04/07/2008	5965
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1429CP	02/01/2008	Modification of Payment Window Edits in the Common Working File (CWF) to Look at Line Item Dates of Service (LIDOS) on Outpatient Claims	07/07/2008	5880
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1341CP	09/21/2007	New Web Site for Approved Transplant Centers	10/22/2007	5724
R1311CP	07/20/2007	Capturing Medicare Advantage (MA) Beneficiary Days in the Medicare Supplemental Security Income (SSI) Fraction for Disproportionate Share Hospital (DSH) Data	01/07/2008	5647
R1268CP	06/15/2007	Update – Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2008	07/02/2007	5652
R1231CP	04/27/2007	The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective	12/03/2007	5474

Rev #	Issue Date	Subject	Impl Date	CR#
		Payment System (IPF PPS) and Clarification of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)		
R1137CP	12/22/2006	Inpatient Rehabilitation Facility (IRF) Teaching Status Adjustment	01/22/2007	5325
R1135CP	12/22/2006	Correction of Instructions for Calculating IRF Compliance Percentage Threshold	03/22/2007	5303
R1105CP	11/09/2006	Swing Bed Hospital Updates	12/11/2006	5114
R1101CP	11/03/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
R1072CP	10/06/2006	Inpatient Prospective Payment System (IPPS) Outlier Reconciliation Technical Corrections	11/06/2006	5286
R982CP	06/16/2006	New Use of Hospital Issued Notices of Noncoverage (HINNs)	09/18/2006	5070
R981CP	06/15/2006	Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007	07/03/2006	5202
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R966CP	05/26/2006	Intestinal and Multi-Visceral Transplantation	06/26/2006	5090
R957CP	05/19/2006	Pancreas Transplants Alone (PA)	07/03/2006	5093
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services – Rescinded and replaced by Transmittal 980	10/02/2006	4014
R938CP	05/05/2006	The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	08/07/2006	5016
R903CP	04/14/2006	Payment for Blood Clotting Factors Administered to Hemophilia Inpatients	07/14/2006	4229
R851CP	02/10/2006	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions Specialty Contractor Regarding Claims for Beneficiaries with RNCHI Elections	05/11/2006	4218
R843CP	02/09/2006	Inpatient Admission Followed by Discharge or Death Prior to Room Assignment	07/03/2006	4202
R836CP	02/03/2006	Inpatient Admission Followed by Discharge or Death Prior to Room Assignment – Rescinded and replaced by Transmittal 843	07/03/2006	4202

Rev #	Issue Date	Subject	Impl Date	CR#
R817CP	01/20/2006	Update to the Inpatient Provider specific File and the Outpatient Provider Specific File to Retain Provider Information	04/03/2006	4279
R803CP	01/03/2006	Administration of Drugs and Biologicals in a Method II Critical Access Hospital (CAH)- Rescinds and Replaces CR 3911	04/03/2006	4234
R776CP	12/06/2005	Stem Cell Transplantation	01/03/2006	4173
R771CP	12/02/2005	Revisions to Pub. 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier	01/03/2006	4181
R768CP	12/02/2005	Lung Volume Reduction Surgery	03/02/2006	4149
R766CP	12/02/2005	Stem Cell Transplantation - Rescinded and replaced by Transmittal 776	01/03/2006	4173
R714CP	10/21/2005	Payment Window Edit Corrections within the Common Working File (CWF)	04/03/2006	4089
R707CP	10/12/2005	IPPS Outlier Reconciliation	11/07/2005	3966
R703CP	10/07/2005	IPPS Outlier Reconciliation – Rescinded and replaced by Transmittal 703	11/07/2005	3966
R698CP	10/07/2005	The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2006 for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	11/07/2005	4065
R693CP	09/30/2005	Updates to the IRF and SNF Provider Specific File and Changes in Inpatient Rehabilitation Facility Prospective Payment System For FY 2006	10/31/2005	4099
R668CP	09/02/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
R654CP	08/19/2005	Services Not Provided Within United States	11/17/2005	3781
R646CP	08/12/2005	Update to the Inpatient Provider Specific File (PSF) and the Outpatient PSF to Retain Provider Information – Rescinded and replaced by Transmittal 817	01/03/2006	3940
R632CP	07/29/2005	Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations	01/03/2006	3949
R622CP	07/29/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933

Rev #	Issue Date	Subject	Impl Date	CR#
R619CP	07/29/2005	Late IRF-PAI Data Submission Penalty Protocol Within the Inpatient Rehabilitation Facility Prospective Payment System	01/03/2006	3885
R594CP	06/24/2005	Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare	07/01/2005	3903
R577CP	06/03/2005	Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare	07/01/2005	3903
R530CP	04/22/2005	Billing Requirements for Physician Services Rendered in Method II Critical Access Hospitals (CAHs)	07/05/2005	3800
R526CP	04/15/2005	Updated Requirements for Autologous Stem Cell Transplantation (AuSCT)	05/16/2005	3797
R478CP	02/18/2005	Clarification of the Verification Process to be Used to Determine if the Inpatient Rehabilitation Facility Meets The IRF Classification Criteria	03/21/2005	3704
R465CP	02/04/2005	Billing Requirements for Physician Services in Method II Critical Access Hospitals (CAHs)	07/05/2005	3559
R392CP	12/10/2004	The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	01/10/2005	3567
R384CP	12/01/2004	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	04/04/2005	3541
R383CP	11/26/2004	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Replaced by Transmittal 384.	04/04/2005	3541
R379CP	11/26/2004	Low Osmolar Contrast Material/Laboratory Tests/Payment for Inpatient Services Furnished by a Critical Access Hospital (CAH)	04/04/2005	3439
R357CP	11/05/2004	Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706	04/04/2005	3529
R347CP	10/29/2004	Inpatient Rehabilitation Facility (IRF) Classification Requirements	11/29/2004	3503
R291CP	08/27/2004	Use of Transmission Date in the Service Date/Assessment Date Field for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims	01/03/2005	3433

Rev #	Issue Date	Subject	Impl Date	CR#
R285CP	08/27/2004	Addition of Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists as Emergency On-Call Providers for Critical Access Hospitals (CAHs)	01/03/2005	3228
R276CP	08/13/2004	Further Information Related to CR 3175, Distinct Part Units of Critical Access Hospitals (CAHs)	01/03/2005	3399
R267CP	07/30/2004	Crossover Patients in New Long Term Care Hospitals (LTCH)	01/03/2005	3391
R266CP	07/30/2004	Revision of Common Working File (CWF) Editing for Same-Day, Same- Provider Acute Care Readmissions	01/03/2005	3389
R263CP	07/30/2004	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer for FY 2005	10/04/2004	3378
R231CP	07/23/2004	Indian Health Service or Tribal Critical Access Hospitals Billing for Professional Services	01/03/2005	3235
R221CP	06/25/2004	Medicare IRF Classification Requirements	07/01/2004	3334
R208CP	06/18/2004	Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update	07/06/2004	3335
R161CP	04/30/2004	Informing Beneficiaries about which local Medical Review Policy (LMRP) and /or Local Coverage Determination (LCD) and o/or National Coverage Determination (NCD) is associated with their claim denial - rescinded and replaced with Pub. 100-08, Transmittal 75.	10/04/2004	3089
R156CP	04/30/2004	Clarification of payments and billing procedures for hospitals subject to the Maryland waiver	10/04/2004	3200
R152CP	04/30/2004	Inclusion of Core-Based Statistical Area (CBSA) Data Elements to the Provider Specific Files	10/04/2004	3272
R144CP	04/23/2004	Distinct Part Units for Critical Access Hospitals	10/04/2004	3175
R087CP	02/06/2004	Expansion of Transfer Policy Under Inpatient Payment Prospective System	07/06/2004	2934
R077CP	02/06/2004	Change in Methodology for Determining Payment for Outliers	03/08/2004	2998
R073CP	01/23/2004	MCE and IPPS Transfers Between Hospitals	N/A	2716 & 2891
R070CP	01/23/2004	Hospital Operating Payments Under PPS	02/23/2004	3038

Rev #	Issue Date	Subject	Impl Date	CR#
R068CP	01/16/2004	New Requirements for Critical Access Hospitals. These changes have been established with the "Medicare Prescription Drug, Improvement, and Modernization Act" (MPDIMA) of 2003, Pub.L. 108-173	04/05/2004	3052
R039CP	12/08/2003	Low-Income Provides Adjustment: The Supplemental Security Income Medicare Beneficiary Data for Fiscal Year 2002 for IRFs Paid Under the PPS	01/05/2004	2978
R026CP	11/04/2003	Lung Volume Reduction Surgery	01/05/2004	2688
R010CP	10/17/2003	Heart Transplants	10/01/2003	2958
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

Back to top of Chapter