CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11941	**Date: April 5, 2023**
	Change Request 13142

SUBJECT: Correction to Manual for Outlier Calculations

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide corrected instructions for outlier calculations.

EFFECTIVE DATE: April 1, 2002
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May5, 2023

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/50/50.4 – Changes to Pricer Logic Effective April 1, 2002
R	4/50/50.5 - Changes to Pricer Logic Effective April 1, 2002

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11941	Date: April 5, 2023	Change Request: 13142

SUBJECT: Correction to Manual for Outlier Calculations

EFFECTIVE DATE: April 1, 2002
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 5, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to is to update Chapter 4 of the Medicare Claims Processing Manual to include SI=K to the exclusion of outlier calculation. 42 CFR 419.43(f) excludes outlier payments for drugs and biologicals paid under a separate APC.

B. Policy: This CR contains no policy changes.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13142.1	Medicare contractors shall be aware of the corrections to Pub. 100-04, Chapter 4 contained in this Change Request.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov (for claims processing questions) , Scott Talaga, Scott.Talaga@cms.hhs.gov (for policy questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

50.4 – Changes to Pricer Logic Effective April 1, 2002

(Rev.11941, Issued:04-05-23, Effective: 04-01-02, Implementation: 05-05-23)

The following list contains a description of all OPPS Pricer logic changes that are effective beginning April 1, 2002.

A. New OPPS wage indexes will be effective April 1, 2002. These are the same wage indexes that were implemented on October 1, 2001, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule, and CMS is using the corrected wage indexes where applicable.

B. Inpatient hospitals considered reclassified on October 1, 2001, will be considered reclassified for OPPS on April 1, 2002.

C. Section 401 designations and floor MSA designations will be considered effective for OPPS on April 1, 2002.

D. New payment rates and coinsurance amounts were effective for OPPS on April 1, 2002, except those 55 APCs with coinsurance amounts limited to 55 percent of the payment rate, which were effective January 1, 2002. The coinsurance limit equal to the inpatient deductible of $812 remains effective January 1, 2002.

E. APC 339, for Observation, will be priced at 1 unit no matter how many units are submitted.

F. If a claim has more than 1 service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines will be summed and the charges will then be divided up proportionately to the payment rate for each S or T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

EXAMPLE:

SI	Charges	Payment Rate	New Charges Amount
S	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
S	$0	$1,000	$2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of S gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 * $20,000 = $12,000.

G. All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional amount

will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.

H. Outliers will be calculated at a line item level. No outlier payment will be calculated for SIs of G, K, N or H, although charges for packaged services (SI=N) will be used in calculating outlier payments for other services as described in G. above. Pricer will use submitted charges as modified by items F and G above. The CMS changed the factor multiplied times the total claim payments from 2.5 to 3.5 and factor used to multiply the difference between claim payments and costs from .75 to .50. Pricer will keep the cost to charge ratio adjustment factor at .981956. Pricer will sum all line item outlier amounts and output them as a single total claim outlier amount, just as it outputs the outlier amount that contractors are to place in value code 17.

I. Any claim with one or more APCs that match those listed in Table 1 of the March 1, 2002, "Federal Register" will have all applicable APC offset amounts summed and wage adjusted. The total wage adjusted offset amount will be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C, i.e., C1713 through C2631.

J. A pro rata reduction of 63.6 percent applies to all SI G and/or H payments. For H, devices, the offset (or reduction) is applied to the final payment amount after all device offset amounts (see item I above) have been taken. For SI G, pass thru drugs, CMS determines the pass-through amount (PTA) by subtracting 5 times the minimum coinsurance from the Medicare payment amount. The CMS will multiply .364 times the PTA and add that amount to 5 times the minimum coinsurance to get the new Medicare payment amount.

K. The provider specific file for SNFs and HHAs that may be reimbursed for splints, casts and/or antigens under OPPS should have a cost to charge ratio of 0.000 (or 0.001 if the shared system will not allow 0.000. Pricer will not pay outliers for these services.

L. Pricer Drug Copayment Changes

M. APC	N. Drug Name	O. Corrected Copayment
P. 726	Q. Dexrazoxane	R. $27.85
S. 1607	T. Eptifibatide	U. $1.62

50.5 - Changes to Pricer Logic Effective April 1, 2002

(Rev.11941, Issued:04-05-23, Effective: 04-01-02, Implementation: 05-05-23)

The following list contains a description of all OPPS Pricer logic changes that are effective beginning April 1, 2002.

V. New OPPS wage indexes will be effective April 1, 2002. These are the same wage indexes that were implemented on October 1, 2001, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule, and CMS is using the corrected wage indexes where applicable.

W. Inpatient hospitals considered reclassified on October 1, 2001, will be considered reclassified for OPPS on April 1, 2002.

X. Section 401 designations and floor MSA designations will be considered effective for OPPS on April 1, 2002.

Y. New payment rates and coinsurance amounts were effective for OPPS on April 1, 2002, except those 55 APCs with coinsurance amounts limited to 55 percent of the payment rate, which were effective January 1, 2002. The coinsurance limit equal to the inpatient deductible of $812 remains effective January 1, 2002.

Z. APC 339, for Observation, will be priced at 1 unit no matter how many units are submitted.

AA. If a claim has more than 1 service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines will be summed and the charges will then be divided up proportionately to the payment rate for each S or T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

EXAMPLE:

SI	Charges	Payment Rate	New Charges Amount
S	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
S	$0	$1,000	$2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of S gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 * $20,000 = $12,000.

BB. All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional amount will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.

CC. Outliers will be calculated at a line item level. No outlier payment will be calculated for SIs of G, K, N or H, although charges for packaged services (SI=N) will be used in calculating outlier payments for other services as described in G. above. Pricer will use submitted charges as modified by items F and G above. The CMS changed the factor multiplied times the total claim payments from 2.5 to 3.5 and factor used to multiply the difference between claim payments and costs from .75 to .50. Pricer will keep the cost to charge ratio adjustment factor at .981956. Pricer will sum all line item outlier amounts and output them as a single total claim outlier amount, just as it outputs the outlier amount that contractors are to place in value code 17.

DD. Any claim with one or more APCs that match those listed in Table 1 of the March 1, 2002, “Federal Register” will have all applicable APC offset amounts summed and wage adjusted. The total wage

adjusted offset amount will be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C, i.e., C1713 through C2631.

EE. A pro rata reduction of 63.6 percent applies to all SI G and/or H payments. For H, devices, the offset (or reduction) is applied to the final payment amount after all device offset amounts (see item I above) have been taken. For SI G, pass thru drugs, CMS determines the pass-through amount (PTA) by subtracting 5 times the minimum coinsurance from the Medicare payment amount. The CMS will multiply .364 times the PTA and add that amount to 5 times the minimum coinsurance to get the new Medicare payment amount.

FF. The provider specific file for SNFs and HHAs that may be reimbursed for splints, casts and/or antigens under OPPS should have a cost to charge ratio of 0.000 (or 0.001 if the shared system will not allow 0.000. Pricer will not pay outliers for these services.

GG. Pricer Drug Copayment Changes

HH. APC	II. Drug Name	JJ. Corrected Copayment
KK. 726	LL. Dexrazoxane	MM. $27.85
NN. 1607	OO. Eptifibatide	PP. $1.62