CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4144	**Date: October 4, 2018**
	Change Request 10869

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 4, 2018. This instruction may now be posted to the Internet.

Transmittal 4129, dated September 7, 2018, is being rescinded and replaced by Transmittal 4144, dated, October 4, 2018, correct a figure in the Medicare Disproportionate Share Hospitals (DSH) Program section and resolve minor clarification and formatting edits throughout the CR. All other information remains the same.

SUBJECT: Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2019 update to the IPPS and LTCH PPS. This Recurring Update Notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Addendum A - Provider Specific File

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:
Recurring Update Notification

Attachment - Recurring Update Notification

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I. GENERAL INFORMATION

A. Background: 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. In addition, 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 Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. This Change Request (CR) outlines those changes for FY 2019.

B. Policy: The following policy changes for FY 2019 were displayed in the Federal Register on August 2, 2018, with a publication date of August 17, 2018. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2018 through September 30, 2019, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2018, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2018 through September 30, 2019. The new revised Pricer program shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

Files for download listed throughout the CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use the following links for files for download on the following pages (when not otherwise specified):

- FY 2019 Final Rule Tables webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Tables.html
- FY 2019 Final Rule Data Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Data-Files.html
- MAC Implementation Files webpage: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-MAC-Implementation.html

Alternatively, the files on the webpages listed above are also available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2019 IPPS Final Rule Home Page" or the link titled "Acute Inpatient--Files for Download" (and select 'Files for FY 2019 Final Rule').

IPPS FY 2019 Update

A. FY 2019 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2019 IPPS/LTCH PPS Final Rule, available on the FY 2019 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, High Cost Outlier (HCO) threshold, and Cost-of-Living adjustment (COLA) factors, refer to MAC Implementation File 1 available on the FY 2019 MAC Implementation Files webpage.

B. Medicare Severity -Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new International Classification of Diseases Tenth Edition (ICD-10) MS-DRG Grouper, Version 36.0, software package effective for discharges on or after October 1, 2018. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 36.0, which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2018.

For discharges occurring on or after October 1, 2018, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation in August 2018.

For discharges occurring on or after October 1, 2018, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2018. Note that the MCE version continues to match the Grouper version.

CMS increased the number of MS-DRGs from 754 to 761 for FY 2019. CMS is implementing 18 new MS-DRGs for FY 2019. In addition, we are deleting 11 MS-DRGs.

FY 2019 New MS-DRGs

MS-DRG 783 Cesarean Section with Sterilization with MCC

MS-DRG 784 Cesarean Section with Sterilization with CC

MS-DRG 785 Cesarean Section with Sterilization without CC/MCC

MS-DRG 786 Cesarean Section without Sterilization with MCC

MS-DRG 787 Cesarean Section without Sterilization with CC

MS-DRG 788 Cesarean Section without Sterilization without CC/MCC

MS-DRG 796 Vaginal Delivery with Sterilization/D&C with MCC

MS-DRG 797 Vaginal Delivery with Sterilization/D&C with CC

MS-DRG 798 Vaginal Delivery with Sterilization/D&C without CC/MCC

MS-DRG 805 Vaginal Delivery without Sterilization/D&C with MCC

MS-DRG 806 Vaginal Delivery without Sterilization/D&C with CC

MS-DRG 807 Vaginal Delivery without Sterilization/D&C without CC/MCC

MS-DRG 817 Other Antepartum Diagnoses with O.R. Procedure with MCC

MS-DRG 818 Other Antepartum Diagnoses with O.R. Procedure with CC

MS-DRG 819 Other Antepartum Diagnoses with O.R. Procedure without CC/MCC

MS-DRG 831 Other Antepartum Diagnoses without O.R. Procedure with MCC

MS-DRG 832 Other Antepartum Diagnoses without O.R. Procedure with CC

MS-DRG 833 Other Antepartum Diagnoses without O.R. Procedure without CC/MCC

FY 2019 Deleted MS-DRGs

MS-DRG 685 Admit for Renal Dialysis

MS-DRG 765 Cesarean Section with CC/MCC

MS-DRG 766 Cesarean Section without CC/MCC

MS-DRG 767 Vaginal Delivery with Sterilization and/or D&C

MS-DRG 774 Vaginal Delivery with Complicating Diagnosis

MS-DRG 775 Vaginal Delivery without Complicating Diagnosis

MS-DRG 777 Ectopic Pregnancy

MS-DRG 778 Threatened Abortion

MS-DRG 780 False Labor

MS-DRG 781 Other Antepartum Diagnoses with Medical Complications

MS-DRG 782 Other Antepartum Diagnoses without Medical Complications

CMS revised the titles to the following MS-DRGs for FY 2019:

FY 2019 MS-DRG Revised Title Descriptions

MS-DRG 11 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy With MCC

MS-DRG 12 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy With CC

MS-DRG 13 Tracheostomy For Face, Mouth & Neck Diagnoses Or Laryngectomy Without CC/MCC

MS-DRG 16 Autologous Bone Marrow Transplant With CC/MCC Or T-Cell Immunotherapy

MS-DRG 864 Fever And Inflammatory Conditions

MS-DRG 207 Respiratory System Diagnosis With Ventilator Support>96 Hours Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)

MS-DRG 291 Heart Failure & Shock With MCC Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)

MS-DRG 296 Cardiac arrest, unexplained w MCC Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)

MS-DRG 870 Septicemia Or Severe Sepsis With MV >96 Hours Or Peripheral Extracorporeal Membrane Oxygenation (ECMO)

See the ICD-10 MS-DRG V36.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V36 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html) for the complete list of FY 2019 ICD-10 MS-DRGs and Medicare Code Edits.

C. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2019 have been evaluated against the general post-acute care transfer policy criteria using the FY 2017 MedPAR data according to the regulations under Sec. 412.4(c). As a result of this review no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy. However MS-DRGs 023 (Craniotomy with Major Device Implant or Acute CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator) and 024 (Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis without MCC or Chemotherapy Implant or Epilepsy with Neurostimulator) were added to the special payment policy list.

See Table 5 of the FY 2019 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2019 Final Rule Tables webpage.

We also note implementation of the inclusion of discharges to hospice care as a post-acute care transfer subject to the payment adjustments beginning in FY 2019, as required by section 53109 of the Bipartisan Budget Act of 2018, was addressed in Change Request 10602 (Transmittal 2094; June 20, 2018).

D. New Technology Add-On

The following items will *continue* to be eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: Defitelio®

- Maximum Add-on Payment: $80,500 (Note, this amount has been updated for FY 2019)

- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 or XW04392

2. Name of Approved New Technology: ZINPLAVA™

- Maximum Add-on Payment: $1,900

- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033A3 or XW043A3

3. Name of Approved New Technology: Stelara®

- Maximum Add-on Payment: $2,400

- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XW033F3

The following items are eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: VYXEOS™

- Maximum Add-on Payment: $36,425
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033B3 or XW043B3

2. Name of Approved New Technology: Remedē® System

- Maximum Add-on Payment: $17,250

- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 0JH60DZ and 05H33MZ **in combination with** procedure code: 05H03MZ or 05H43MZ

3. Name of Approved New Technology: GIAPREZA™

- Maximum Add-on Payment: $1,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033H4 or XW043H4

4. Name of Approved New Technology: AndexXa™

- Maximum Add-on Payment: $14,062.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03372 or XW04372

5. Name of Approved New Technology: Sentinel® Cerebral Protection System™

- Maximum Add-on Payment: $1,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: X2A5312

6. Name of Approved New Technology: Aquabeam®

- Maximum Add-on Payment: $1,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XV508A4

7. Name of Approved New Technology: VABOMERE™

- Maximum Add-on Payment: $5,544
- Identify and make new technology add-on payments with an NDC of 70842012001 or 65293000901 (VABOMERE™ Meropenem-Vaborbactam Vial)

8. Name of Approved New Technology: ZEMDRI™ (Plazomicin)

- Maximum Add-on Payment: $2,722.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033G4 or XW043G4

9. Name of Approved New Technology: Kymriah®/Yescarta®

- Maximum Add-on Payment: $186,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033C3 or XW043C3

E. Cost of Living Adjustment (COLA) Update for IPPS PPS

There are no changes to the COLA factors for FY 2019. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2018, can be found in the FY 2019 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2019 MAC Implementation Files webpage.

F. Wage Index Changes and Issues

1. New CBSA

In OMB Bulletin No. 17–01, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. As discussed in the FY 2019 final rule, effective for FY 2019 new urban CBSA is as follows:

• Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

MACs should be sure to update the applicable CBSA fields in the PSF to CBSA 46300, for any hospitals located in in Twin Falls County, Idaho, or Jerome County, Idaho, with an effective date of October 1, 2018. Additional instructions regarding this change will be provided in the file posted on the FY 2019 MAC Implementation File webpage concerning updating the PSF for wage index, reclassifications and redesignations.

2. Section 505 Hospitals (Out-Commuting Adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment,” is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under § 412.103, or redesignated under section 1886(d)(8)(B) of the Act.

For FY 2019, Pricer will assign the out migration adjustment using the County Code (data element 60) field in the PSF. Therefore, MACs shall ensure that every hospital has listed in data element 60 the FIPS (Federal Information Processing Standard Publication) county code where the hospital is located. Complete instructions to fill out the PSF for the wage index are available on the FY 2019 MAC Implementation File webpage.

As explained in CR 10273 (Transmittal 3885; October 17, 2017), beginning with FY 2018 MACs will not need to insert a "1" to data element 33 and the wage index value in data element 38. Therefore, for all IPPS providers, **MACs shall ensure that no hospital has a "1" or "2" in the Special Payment Indicator (data element 33) field and no wage index value in the Special Wage Index field (data element 38) with an effective date of October 1, 2018 or later.** Effective October 1, 2018, unless otherwise instructed by CMS, MACs shall seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).

G. Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act and Certain Urban Hospitals Reclassified as Rural Hospitals Under § 412.103

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. The list of hospitals that have waived Lugar status for FY 2019 can be found on the FY 2019 MAC Implementation File webpage. Complete details on how to fill out the PSF for these hospitals are available on the FY 2019 MAC Implementation File webpage.

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under § 412.103 are not eligible for the capital Disproportionate Share Hospitals (DSH) adjustment since these hospitals are considered rural under the capital PPS (see § 412.320(a)(1)).

H. Multicampus Hospitals

1. Wage Index

Beginning with the FY 2008 wage index, we instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CCN of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also, note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF, (see the FY 2019 MAC Implementation File webpage). In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers. In addition, if MACs learn of additional mergers during FY 2019 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact Miechal.Kriger@cms.hhs.gov and Michael.Treitel@cms.hhs.gov for instructions.

2. Qualification for Certain Special Statuses

In the FY 2019 Final rule, CMS codified its current policies regarding how multicampus hospitals may qualify for special status as a sole-community hospital (SCH), rural referral center (RRC), Medicare-

dependent hospital (MDH), and rural reclassification under § 412.103. Specifically, the main campus of a hospital cannot obtain a SCH, RRC, or MDH status or rural reclassification independently or separately from its remote location(s), and vice versa. Rather, the hospital (the main campus and its remote location(s)) are granted the special treatment or rural reclassification as one entity if the criteria are met. To meet the criteria, combined data from the main campus and its remote location(s) are used where the regulations at § 412.92 for SCH, § 412.96 for RRC, § 412.103 for rural reclassification, and § 412.108 for MDH require data, such as bed count, number of discharges, or case-mix index, for example. Where the regulations require data that cannot be combined, specifically qualifying criteria related to location, mileage, travel time, and distance requirements, the hospital needs to demonstrate that the main campus and its remote location(s) each independently satisfy those requirements in order for the entire hospital, including its remote location(s), to be reclassified as rural or obtain a special status.

I. Updating the PSF for Wage Index, Reclassifications and Redesignations

MACs shall update the PSF by following the steps, in order, in the file on the FY 2019 MAC Implementation File webpage, to determine the appropriate wage index and other payments.

J. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospital (MDH) Program

1. Updating the Hospital Specific (HSP) Rate in the PSF

For FY 2019, MACs must update the Hospital-Specific (HSP) amount in the PSF for all SCHs and MDHs. The HSP amount must be updated from FY 2012 dollars to FY 2018 dollars by applying an update factor of 1.04058 to the current HSP amount in the PSF before entering this final amount in the PSF with an effective date of 10/1/2018. The factor of 1.04058 represents the product of all of the annual market basket updates (i.e., applicable percentage increases), the DRG budget neutrality factors for FYs 2013 through 2018, and the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480. PRICER will apply the update and DRG budget neutrality factor to the HSP amount for FY 2019.

2. Effective Date of SCH/MDH Status

For applications received on or after October 1, 2018, the effective date for MDH or SCH status is the date the MAC received the complete application (per revised § 412.108(b)(4) and § 412.92 (b)(2)(i)). An application is considered complete on the date the MAC received all supporting documentation needed to conduct the review.

3. Update to PSF for Extension of the MDH Program

Prior to October 1, 2012, under current law at that time, the MDH program expired at the end of FY 2012. The MDH program has been extended by subsequent legislation, most recently by the Bipartisan Budget Act of 2018, which extended the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022) (See CR 10547 for reference). The PSF file data dictionary is being updated to reflect this change in law (that is, provider type 14 and 15 are valid until 10/01/2022).

K. Low-Volume Hospitals – Criteria and Payment Adjustments for FY2019

Section 50204 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) modified the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Specifically, section 50204 amended the qualifying criteria for low-volume hospitals to specify that, for FYs 2019 through 2022, a subsection (d) hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 3,800 total discharges during the fiscal year. Section 50204 also amended the statute to provide that, for discharges occurring in FYs 2019 through 2022, the Secretary shall determine the applicable percentage increase using a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for hospitals with 500 or

fewer discharges to 0 percent additional payment for hospitals with more than 3,800 total discharges in the fiscal year. A hospital's total discharges, which includes Medicare and non-Medicare discharges, is based on the hospital's most recently submitted cost report. The regulations implementing the hospital payment adjustment policy are at § 412.101.

For FY 2019, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2018, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2018 (through September 30, 2019). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2018 may continue to receive a low-volume hospital payment adjustment for FY 2019 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2019. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2018, stating that it meets the mileage criterion applicable for FY 2019. If a hospital's request for low-volume hospital status for FY 2019 is received after September 1, 2018, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2019 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For FY 2019, for each qualifying hospital, MACs must determine the low-volume hospital payment adjustment using the hospital's total discharges in its most recently submitted cost report as of the time of the MAC's low-volume hospital status determination as follows:

- For hospitals with 500 or fewer total discharges, the adjustment is an additional 25 percent for each Medicare discharge.

- For hospitals with 501 and fewer than 3,800 total discharges, the adjustment for each Medicare discharge is an additional percent calculated using the formula: (95 / 330) – (number of total discharges / 13,200)

As noted above, "number of total discharges" includes Medicare and non-Medicare discharges and based on the hospital's most recently submitted cost report at the time of the hospital's low-volume hospital payment adjustment request.

For FY 2019 discharges, the Pricer will calculate the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF using the adjustment factor value in the LV Adjustment Factor field on the PSF. Therefore, if a hospital qualifies for the low-volume hospital payment adjustment for FY 2019, the MAC must ensure the low-volume indicator field on the PSF (position 74 – temporary relief indicator) holds a value of 'Y'. For such hospitals, the MAC must also update the LV Adjustment Factor on the PSF (positions 252 - 258) to hold the value of the low-volume hospital payment adjustment factor (determined by the formula described above). Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2018 but no longer meets the low-volume hospital definition for FY 2019, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2018, the MAC must update the low-volume indicator field to hold a value of 'blank' and update the LV Adjustment Factor on the PSF to hold a value of 'blank'.

L. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: www.qualitynet.org. A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that will receive the quality initiative bonus. The field shall be left blank for hospitals that will receive the statutory reduction under the Hospital Inpatient Quality Reporting (IQR) Program. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and MACs shall update the provider file as needed. A list of hospitals that will receive the

statutory reduction to the annual payment update for FY 2019 under the Hospital IQR Program are found in MAC Implementation File 3 available on the FY 2019 MAC Implementation Files webpage.

For new hospitals, A/B MACs shall enter a '1' in the PSF and provide information to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) as soon as possible so that the Hospital Inpatient VIQR SC can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the Hospital Inpatient VIQR SC the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital IQR Program reporting requirements. The MACs shall provide this information monthly to the Hospital Inpatient VIQR SC. It shall include: State Code, Medicare Accept Date, Provider Name, Contact Name and email address (if available), Provider ID number, physical address, and Telephone Number.

M. Hospital Acquired Condition Reduction Program (HAC)

The Hospital-Acquired Conditions (HAC) Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals with respect to HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment adjustment applies to all Medicare discharges for that fiscal year.

We did not make the list of providers subject to the HAC Reduction Program for FY 2019 public in the final rule because hospitals have until August 2018 to notify CMS of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Corrections period. Updated hospital level data for the HAC Reduction Program will be made publicly available on the Hospital Compare website in January 2019. If necessary, MACs will receive a preliminary list of hospitals subject to the HAC Reduction Program in a Technical Direction Letter (TDL). Until CMS issues final values, contractors shall enter 'N' in the HAC Reduction Indicator field.

N. Hospital Value Based Purchasing (VBP)

For FY 2019 CMS will implement the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2019. CMS expects to post the final value-based incentive payment adjustment factors for FY 2019 in the near future in Table 16B of the FY 2019 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2019 IPPS/LTCH PPS Final Rule Tables webpage). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2019 in Table 16B are available)

Upon receipt of this file, the MACs must update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital VBP Program and the claims processing contractors must update the Hospital VBP Program adjustment field (VBP Adjustment) to input the value-based incentive payment adjustment factor. Note that the values listed in Table 16A of the FY 2019 IPPS/LTCH PPS Final Rule are proxy values. These values are not to be used to adjust payments.

Until CMS issues final values, contractors shall enter 'N' in the VBP Participant field.

O. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2019 in the near future in Table 15 of the FY 2019 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2019 IPPS Final Rule Tables webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2019 in Table 15 are available.) Hospitals that are not subject to a reduction under the HRRP in FY 2019 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY

2019, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

Upon receipt of this file, the MACs must update the Hospital Readmissions Reduction Program participant (HRR Participant) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2018 as follows:

- If a provider has a HRRP payment adjustment factor on Table 15, MACs shall input a value of '1'in the HRR Participant field and enter the HRRP payment adjustment factor in the HRR Adjustment field.
- If a provider is not listed on Table 15, MACs shall input a value of '0' in the HRR Participant field and leave the HRR Adjustment field blank.

Until CMS issues final values, contractors shall enter '0' in the HRRP Participant field.

P. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of the aggregate amount available for uncompensated care payments based on its share of total uncompensated care reported by Medicare DSH hospitals.

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2019 IPPS Final Rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2019. The Uncompensated Care Per Discharge Amount and Projected DSH Eligibility are located in the Medicare DSH Supplemental Data File for FY 2019, which are available through the Internet on the FY 2019 Final Rule Data Files webpage.

MACs shall enter the updated estimated per discharge uncompensated care payment amounts in data element 57 in the PSF from the FY 2019 IPPS Final Rule: Medicare DSH Supplemental Data File, as described below. The total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

For FY 2019, new hospitals with a CCN established after October 1, 2015 that are eligible for Medicare DSH will have their Factor 3 calculated at cost report settlement using uncompensated care costs reported on Line 30 of Worksheet S-10 as the numerator and a denominator of $30,210,112,106. Factor 3 is then applied to the total uncompensated care payment amount finalized in the FY 2019 IPPS Final Rule to determine the total amount to be paid to the hospital. If a new hospital has a CCR on line 1 of Worksheet S-10 in excess of 0.93, MACs will contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as new. We note, it is possible that there are additional new hospitals during FY 2019 and therefore those would not be listed on the Medicare DSH Supplemental Date File. In the case of a new hospital in Puerto Rico, the hospital's Factor 3 would need to be calculated by the MAC based on cost report's Medicaid days, which may need to be annualized, plus 14% for SSI proxy, and then divided by denominator of 37,539,919.

For FY 2019, newly merged hospitals, e.g. hospitals that have a merger during FY 2019, will have their pro rata Factor 3 reconciled at cost report settlement by the MAC. The Factor 3 is calculated based on annualizing both provider's uncompensated care data (line 30) and combining with the respective surviving CCN.

Q. Recalled Devices

A hospital's IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS- DRGs that were already on the list. There are no new MS-DRGs or revisions to the current list for FY 2019 subject to the policy for replaced devices offered without cost or with a credit.

LTCH PPS FY 2019 Update

A. FY 2019 LTCH PPS Rates and Factors

The FY 2019 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2019 Final Rule Tables webpage. Other FY 2019 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2019 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 36.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2018, and on or before September 30, 2019.

B. Application of the Site Neutral Payment Rate

Section 1886(m)(6) of the Act establishes patient-level criteria for payments under the LTCH PPS for cost reporting periods beginning on or after October 1, 2015. LTCH discharges that do not meet the patient-level criteria are paid the site neutral payment rate. The application of the site neutral payment rate is codified in the regulations at § 412.522.

The statute originally established a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which was extended by subsequent legislation to cost reporting periods beginning during FY 2018 and FY 2019. The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge. This transitional blended payment rate for site neutral rate LTCH discharges is included in the Pricer logic, and MACs shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date. Specifically, the MACs shall ensure that for cost reporting period beginning during FY 2018 or 2019, the blend year indicator is set to "7."

Under section 51005 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123), the IPPS comparable amount under the site neutral payment rate is reduced by 4.6 percent for FYs 2018 through 2026. This adjustment is included in the Pricer logic.

The temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs expires for cost reporting periods that begin on or after October 1, 2018. Upon expiration of this temporary statutory provision, as instructed in CR 10185, the MAC will set the Temporary Relief Indicator field on the PSF to an 'N' to be effective the start of the hospital's FY 2019 cost reporting period.

C. The 25-Percent Threshold Policy

CMS eliminated the 25-percent threshold policy in the FY 2019 IPPS/LTCH PPS final rule, effective October 1, 2018. Accordingly, the regulations describing the 25-percent threshold policy at § 412.538 have

been removed and reserved.

D. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2019, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality-reporting data in accordance with the LTCHQR Program for that year. MACs will receive more information under separate cover.

E. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2018, or effective with cost reporting periods that begin on or after October 1, 2018, or upon receipt of an as-filed (tentatively) settled cost report.

In OMB Bulletin No. 17–01, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Area. As discussed in the FY 2019 final rule, effective for FY 2019 new urban CBSA is as follows:

• Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho.

MACs should be sure to update the applicable CBSA fields in the PSF to CBSA 46300, for any hospitals located in in Twin Falls County, Idaho, or Jerome County, Idaho, with an effective date of October 1, 2018.

NOTE: CR 10368 directed MACs to ensure the value of '1' in the CBSA Special Pay Indicator field in the FY 2018 PSF (data element 33) and the wage index values for CBSAs 25980 through 49740 in the Special Wage Index field in the PSF (data element 38). MACs will ensure the value of '1' in the CBSA Special Pay Indicator field (and any wage index value in the Special Wage Index field) is not carried over in the PSF FY 2019.

Table 8C contains the FY 2019 Statewide average LTCH total Cost-to-Charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2019 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2019, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital’ s provider agreement in accordance with 42 CFR section 489.18).
2. LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).
3. Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

F. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2019. The COLAs effective for discharges occurring on or after October 1, 2018 can be found in the FY 2019 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2019 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2019.)

G. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon final settlement of the cost report. MACs may use the form letter available on the Internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage.

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2019 IPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2018 of 2.9 percent.

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	
10869.1	The Medicare contractor shall install and pay claims with the FY 2019 IPPS Pricer for discharges on or after October 1, 2018.					X				
10869.2	The Medicare contractor shall install and pay claims with the FY 2019 LTCH Pricer for discharges on or after October 1, 2018.					X				
10869.3	The Medicare contractor shall install and edit claims with the MCE version 36.0 and Grouper version 36.0 software with the implementation of the FY 2019 October quarterly release.					X				
10869.4	The Medicare contractor shall establish yearly recurring hours to allow for updates to the list of ICD-10-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** The list of ICD-10-CM diagnosis codes exempt from reporting POA are displayed on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10869.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
10869.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 8, 2018.	X								
10869.6.1	Medicare contractors shall follow the instructions in the policy section and on the FY 2019 MAC Implementation File webpage to update the PSF and ensure that the CBSA is assigned properly for all IPPS providers. **NOTE**: MACs must follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2019; or any change of hospital status during FY 2019.	X								
10869.7	Medicare contractors shall ensure that the Fiscal Year Beginning Date field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.	X								
10869.8	For hospitals paid under the IPPS, Medicare contractors shall remove the 'Y' low-volume indicator in the PSF (position 74 - temporary relief indicator) and remove the LV Adjustment Factor (positions 252-258) for providers who no longer qualify as a low-volume hospital. For hospitals paid under the IPPS who qualify as a low-volume hospital for FY 2019, Medicare contractors shall ensure the low-volume indicator in the PSF holds a value of 'Y' and the LV Adjustment Factor holds the hospital's applicable low-volume hospital adjustment factor as described in the IPPS policy section of this CR.	X								
10869.9	Medicare contractors shall be aware of any manual updates included within this CR.	X								
10869.10	The CWF shall update edit and IUR 7272 as necessary for the post-acute DRGs listed in Table 5 of the IPPS Final Rule when changes are made.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: There are no changes to the post-acute DRGs listed in Table 5 in the FY 2019 IPPS Final Rule. However, MS-DRGs 023 and 024 have been added to the special payment policy list.									
10869.11	MACs shall update the Hospital-Specific (HSP) amount in the PSF for all SCHs and MDHs as described in the IPPS policy section of this CR.	X								
10869.12	For each LTCH's cost reporting period beginning on or after October 1, 2018, contractors shall determine the LTCH's discharge payment percentage by dividing the number of LTCH PPS standard Federal payment rate discharges by the total number of LTCH PPS discharges.	X								
10869.12.1	For each LTCH's cost reporting period beginning on or after October 1, 2018, at settlement of such cost reporting period contractors shall inform LTCHs in writing of their discharge payment percentage. An example letter for informing an LTCH of its discharge payment percentage can be found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html	X								
10869.13	Effective October 1, 2018, unless otherwise instructed by CMS, MACs shall seek approval from the CMS central office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).	X								
10869.14	Contractors shall evaluate all local edits that contain ICD-10-CM and ICD-10-PCS codes, update, and test as needed.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10869.15	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov

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

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Addendum A - Provider Specific File

(Rev.4144, Issued-10-04-18, Effective: 10-01-18, Implementation: 10-01-18)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
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):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>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</td></tr>
</table>

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). 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality 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 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing

Data Element	File Position	Format	Title	Description
				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.
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

Data Element	File Position	Format	Title	Description
				_ _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 updated base year for the operating hospital specific rate. See §20.6. Must be completed for any SCH or MDH, even if the hospital will be paid at the Federal rate.
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.

Data Element	File Position	Format	Title	Description
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. *Effective for cost reporting periods beginning on or after 10/01/2017 and before 10/01/2018, 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)), as set forth in the regulations at §412.522(b)(3).* *Effective for cost reporting periods beginning on or after 10/01/2017, and on or before 09/30/2019, code an 'S' for an LTCH that qualifies for the temporary exception for certain spinal cord specialty hospitals 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

Data Element	File Position	Format	Title	Description
				0 = Pay standard percentages 1 = Pay zero percent **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 — Federal % 40 — Facility% 60 3 — Federal % 60 — Facility% 40 4 — Federal % 80 — Facility% 20 5 — Federal % 100 — Facility% 00 *For LTCH Cost reporting periods beginning on or after 10/01/2015 enter the appropriate code for the blend year representing 50% site neutral payment and 50 % standard payment.* *6 –Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015 through 09/30/16)* *7 - Blend Years 2 through 4 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019* *8 - Blank – Transition Blend no longer applies with cost reporting periods beginning in on or after 10/01/2019. Full Site Neutral payment.* **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 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25

Data Element	File Position	Format	Title	Description
				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.
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.

Data Element	File Position	Format	Title	Description
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.)
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.

Data Element	File Position	Format	Title	Description
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.
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

Data Element	File Position	Format	Title	Description
				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 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 in accordance with the low-volume hospital payment regulations at § 412.101.
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-310	X(47)	Filler	