CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4257	**Date: March 14, 2019**
	Change Request 10971

Transmittal 4230, dated February 1, 2019, is being rescinded and replaced by Transmittal 4257, dated, March 14, 2019 to update elements of the Provider Specific File in chapters three and four of the Medicare Claims Process Manual. All other information remains the same.

SUBJECT: Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model

I. SUMMARY OF CHANGES: This Change Request (CR) implements adjusted payment amounts for hospital claims in Maryland as part of the Maryland Total Cost of Care (MD TCOC) Model. The change in hospital payments in the state of Maryland will include a reduction in payments on hospital claims by 1% structure.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019 - Coding and Implementation

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	4/50.1/ Outpatient Provider Specific File
R	3/Addendum A/ Provider Specific File
R	4/190/Payer Only Codes Utilized by Medicare

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: 4257	Date: March 14, 2019	Change Request: 10971

Transmittal 4230, dated February 1, 2019, is being rescinded and replaced by Transmittal 4257, dated, March 14, 2019 to update elements of the Provider Specific File in chapters three and four of the Medicare Claims Process Manual. All other information remains the same.

SUBJECT: Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 1, 2019 - Coding and Implementation

I. GENERAL INFORMATION

A. Background: CMS is amending the Maryland All-Payer Model to require the State to make a performance adjustment to the hospital global budgets. This adjustment is the Medicare Performance Adjustment (MPA).

Under the Maryland All-Payer Model, the State has met its hospital savings targets by setting a statewide global budget update factor, which is the amount by which hospital global budgets change year-over-year. Under the upcoming Maryland Total Cost of Care (MD TCOC) Model—slated to begin January 1, 2019—the State will similarly be required to meet an annual savings target. However, unlike the Maryland All-Payer Model, the State will adjust the global budgets as necessary to offset any excess growth in nonhospital costs in order to meet the annual savings targets under the MD TCOC Model (the "update factor"). However, the link between the State's annual savings target and nonhospital savings is indirect and creates a risk that CMS' investment in the Maryland Primary Care Program (MDPCP) will exceed the savings from the Global Budget Program if the State does not set the global budgets conservatively.

Additionally, the growth rate in hospital global budgets is determined on a statewide basis and applied uniformly across hospitals, but hospitals do not contribute equally to the State's total cost of care, on either an aggregate or a per capita basis. For example, Johns Hopkins Hospital has a higher per capita cost than Garrett County Hospital, and likely furnishes more services as well. With a greater contribution to Maryland's total cost of care, Johns Hopkins Hospital has more ability, and thus should have greater responsibility, to influence the State's annual savings targets imposed under the MD TCOC Model State Agreement.

To address this concern, the MD TCOC Model will include a Medicare Performance Adjustment (MPA) that will directly link Medicare total cost of care to hospital expenditures. For purposes of calculating the MPA, each hospital will have an attributed beneficiary population with a Total Cost of Care Benchmark. If the Total Cost of Care Performance for the hospital's attributed population exceeds this Total Cost of Care Benchmark, then the hospital's global budget will be adjusted downward in future rate years to account for the Medicare costs in excess of the Total Cost of Care Benchmark.

The MPA serves several purposes: first, it ensures that there is a direct link between nonhospital costs and payments to Maryland hospitals; second, it allows the State to hold hospitals accountable for their contribution to reducing total cost of care; third, it ensures that hospitals have an incentive to focus on activities that are happening elsewhere in the delivery system.

Another benefit of the MPA is its independence from the all-payer nature of the global budget calculation methodology. While the MD TCOC Model's annual savings targets are Medicare-specific, the State will set global budgets on an all-payer basis under the MD TCOC Model. If the State were to reduce Medicare costs by reducing the global budgets, hospital revenues from all other payers would decline as well, and the

resulting cuts likely would be unsustainable for the hospitals. The MPA allows the State greater flexibility to control Medicare TCOC without simultaneously changing all-payer hospital revenues.

B. Policy: Each hospital will have an attributed beneficiary population and a Total Cost of Care Benchmark for those beneficiaries. If the Total Cost of Care Performance for the hospital's attributed beneficiaries exceeds this Total Cost of Care Benchmark, Medicare payments to the hospital during the subsequent rate year will be reduced by the amount of the MPA; if the hospital's Total Cost of Care Performance is less than the Total Cost of Care Benchmark, the hospital's Total Cost of Care Benchmark will increase by the amount of the MPA for that rate year.

- Attribution Process: CMS will allow the Health Services Cost Review Commission (HSCRC), an independent regulatory agency in Maryland with the authority to oversee the state's hospital rate-setting system, to create an attribution algorithm to attribute beneficiaries to hospitals. All Maryland residents who are Medicare beneficiaries will be attributed to at least one hospital. The State intends to utilize a two-stage attribution algorithm. First, a beneficiary will be assigned to a hospital based on where he receives the plurality of his care. This could include attributing a beneficiary to a hospital if the beneficiary is attributed to an ACO in which the hospital is a participant. Alternatively, the beneficiary could be attributed to the hospital where they receive the plurality of their hospital services. Second, a beneficiary who does not have any hospital utilization will be attributed to the hospital in whose service area he resides.

- TCOC Benchmarking Process: The HSCRC will determine the Total Cost of Care Baseline for each hospital by aggregating all Medicare Part A and Part B costs for the hospital's attributed beneficiaries during the previous 12-month period, subject to certain CMS-approved adjustments and exclusions. These baseline costs will be adjusted by a total cost of care trend factor, which will be determined by the HSCRC on an annual basis based on the annual savings target, subject to CMS review and approval. The result is the Total Cost of Care Benchmark.

- Capping Revenue at Risk: The HSCRC will cap hospital revenue at risk due to the MPA. A hospital will not be able to lose or gain more than this Maximum Revenue at Risk. Initially, for Performance Year 1 (2019), the Maximum Revenue at Risk will be capped at 1 percent of the hospital's Medicare revenues. The HSCRC may request to increase or decrease the Maximum Revenue at risk under the MPA for a subsequent year, subject to CMS review and approval, if it determines that doing so is necessary to meet the annual savings targets.

- Maximum Performance Threshold: Unlike Accountable Care Organization (ACO) models and other Center for Medicare and Medicaid Innovation (CMMI) models, the MD TCOC Model does not employ a "marginal savings rate" mechanism in setting and managing hospital global budgets. For purposes of the MPA, the HSCRC uses a Maximum Performance Threshold, which is the percentage above or below the Total Cost of Care Benchmark at which the Maximum Revenue at Risk is applied.

- For example, if the Maximum Revenue at Risk is 1 percent and the Maximum Performance Threshold is 3 percent, TCOC Performance would have to exceed the TCOC Benchmark by 3 percent for the hospital to lose all of its Maximum Revenue at Risk. An effective marginal savings rate can be calculated by dividing the Maximum Revenue at Risk by the Maximum Performance Threshold. In the example above, the marginal savings rate is 33.3% (i.e., 1% / 3% = 33.33%). The HSCRC may increase the Maximum Performance Threshold, subject to CMS review and approval, but will be required to maintain a Maximum Performance Threshold so that the minimum effective marginal savings rate is at least 30% (in 2019 the Maximum Performance Threshold will be 3.33%, e.g. / 3.33% = 30%).

- Quality Adjustment Score: The MPA will be subject to a quality adjustment score. For this purpose, the HSCRC will use a subset of the same Quality Based Reimbursement (QBR) scores that it employs in setting the hospital global budgets under the MD TCOC model. A Maryland hospital's QBR score is calculated identically to scores under Medicare's Hospital Value-Based Purchasing (HVBP) program, as described above, but the State chooses the quality measures to be included in QBR, conditioned on CMS' continued determination that the QBR program is equivalent to the HVBP program. The HSCRC will continue to choose quality measures that may be included in QBR, but will now be required to use a minimum of two Merit-Based Incentive Payment System (MIPS)-equivalent measures in the QBR. The same two MIPS-equivalent measures will be used in the MPA.

- Medicare Performance Adjustment Formula: The MPA will be equal to the lesser of A) the Maximum Revenue at Risk, or B) [Total Cost of Care Benchmark – Total Cost of Care Performance] / Total Cost of Care Benchmark * [Maximum Revenue at Risk / Maximum Performance Threshold] * Quality Adjustment Score. The amount by which the hospital's Medicare payments will be adjusted by the MPA in the following rate year will be equal to the MPA * the Medicare portion of hospital's global budget.

The MPA process timeline is shown in Figure 1 (attached). The years of the MD TCOC Model for which the MPA will be in effect each align with a calendar year. The HSCRC sets global budgets on a July-June fiscal year. From January to December, the hospital will be accountable for the total cost of care. In May, after 3-month claims run out, HSCRC will determine the MPA Trend Factor, assess each hospital's TCOC Performance relative to the Total Cost of Care Benchmark, and set the next year's Total Cost of Care Benchmark. In July of that calendar year, the hospital's MPA amount will be operationalized according to the process described below. For instance, from January-June of calendar year 2021, the HSCRC will calculate each hospital's TCOC Performance for calendar year 2019 and then the MPA percentage. CMS shall reduce (or increase) the Medicare payments to each hospital in the following rate year by that MPA percentage. The MPA for a hospital's Total Cost of Care Performance for calendar year 2019 will be in effect from July 1, 2020 through June 30, 2021.

Under this process, a hospital's Total Cost of Care Benchmark will be determined *after* the performance year. Hospitals will not know their Total Cost of Care Benchmark in advance of the year; although the HSCRC will release a preliminary Total Cost of Care Benchmark in order to set hospitals' expectations. The HSCRC has decided on a retrospective Total Cost of Care Benchmark because the purpose of the MPA is not to set a total cost of care target for the individual hospitals; but rather to attain a statewide total cost of care target based on the State's annual savings targets. The MPA adjusts hospitals' global budgets based on their relative contribution to attaining those state targets.

Operationalization

CMS will operationalize the MPA by reducing future Medicare payments for hospital services during the following rate year (July through June beginning the 12-month period after the MPA year) based on the Medicare portion of the hospitals' global budgets. CMS will adjust such payments on all hospital claims based on the calculated MPA. For example, if the MPA is 0.35%, CMS will reduce by 0.35% the amount paid to hospitals for all claims during the July through June rate year.

The HSCRC has requested that the MPA be operationalized as a reduction in future Medicare payments to hospitals, rather than a nonclaims-based payment to hospitals, for two reasons. First, the HSCRC already oversees hospital payment rates. Operationalizing the MPA through payments to hospitals will simplify the State's oversight function. Second, claims-based payments are captured in the statewide total cost of care calculation. Nonclaims-based payments must be added to total cost of care calculation retrospectively,

which would make real-time adjustments to the hospital global budgets and the MPA impossible.

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	
10971.1	The CMS Inpatient Provider-Specific File (PSF) record shall be updated to include a new field to carry the Medicare Performance Adjustment (MPA) in data element 61, file position 264-268, format 9V9999 (5 positions for the percentage).									CMS
10971.2	The Medicare Contractor shall add a field to the Inpatient PSF, Data Element 61, file position 264-file position 264-268, format 9V9999 to store the MPA.					X				IDR
10971.2.1	The Medicare Contractor shall add an MPA field to the Inpatient PSF (MAP1142).					X				
10971.3	The Medicare Contractor shall edit the 'MPA' field to ensure that if any data are present it must be in a 5-digit numeric value (9.9999 format) when a record is created, copied or updated for providers.					X				
10971.4	The Medicare Contractor shall apply the MPA value after the beneficiary cost sharing deductions and before sequestration on all MD acute care inpatient hospital claims with a through date on or after July 1, 2019.					X				
10971.4.1	The Medicare Contractor shall report the MPA amount calculated in BR 10971.5 in payer only value code 'Q9'.					X				HIGLAS, IDR
10971.5	The Medicare Contractor shall update the following inpatient reports (and any other reports identified by the Medicare Contractor not listed below) with the new MPA field and the ability to accept the new PSF layout as input. • Report #710 - Inpatient Provider Specific Master File Maintenance Report • Report #964 – Inpatient Provider Specific Master File Maintenance Report • Report #967 - Inpatient Provider Specific Master File Maintenance Report					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10971.6	The Medicare Contractor shall ensure that the inpatient PSF record sent to CMS on a quarterly basis includes the new field.					X				
10971.7	Medicare contractors shall load the MPA into the Inpatient PSF when instructions are received from CMS via a Technical Direction Letter (TDL).	X								
10971.8	The CMS Outpatient PSF record shall be updated to include a new field to carry the MPA in file position 129-133, format 9V9999 (5 positions for the percentage).									CMS
10971.9	The Medicare Contractor shall apply the MPA value after the beneficiary cost sharing deductions and before sequestration at the line level on all Maryland outpatient hospital claims with a service date on or after July 1, 2019.					X				
10971.9.1	The Medicare Contractor shall report the MPA amount in payer only value code 'Q9'.					X				HIGLAS
10971.10	The Medicare Contractor shall add a field to the Outpatient PSF (field 129-133), format 9V9999 to store the MPA.					X				
10971.10.1	The Medicare Contractor shall add an MPA field to the Outpatient PSF (MAP1C12).					X				
10971.11	The Medicare Contractor shall edit the 'MPA' field to ensure that if any data is present it must be in a 5-digit numeric value (9.9999 format) when a record is created, copied or updated for providers.					X				
10971.12	Medicare Contractors shall update the following outpatient reports (and any other reports identified by the Medicare Contractor not listed below) with the new MPA field and the ability to accept the new PSF layout as input. • REPORT # 709 -Outpatient Provider Specific Master File Maintenance Report • REPORT # 961 -Outpatient Provider Specific Master File Maintenance Report • REPORT # 968 -Outpatient Provider Specific Master File Maintenance Report					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10971.13	The Medicare Contractor shall ensure that the outpatient PSF record sent to CMS on a quarterly basis includes the new field.					X				
10971.14	Medicare contractors shall load the MPA into the Outpatient Provider Specific File when instructions are received from CMS via a TDL.	X								
10971.15	The Medicare contractor shall add a new line level field to the claim record to capture the MPA amount calculated in BR 10971.9.1. **NOTE**: The Expert Claims Processing System (ECPS) shall also add the new line level field.					X				IDR
10971.15.1	The Medicare contractor shall add the new line level field to the online claim screen.					X				
10971.16	The Medicare contractor shall assign GROUP code CO and Claim Adjustment Reason Code (CARC) 161 – Provider performance bonus when the MPA is positive and CARC 245 – Provider performance program withhold when the MPA is negative Note: The MPA will not be reported on the Medicare Summary Notice (MSN).					X				
10971.16.1	The Medicare contractor shall move the claim level MPA amount on inpatient claims to the 2100 Claim Adjustment Segment (CAS) segment on the Electronic Remittance Advice (ERA).					X				
10971.16.2	The Medicare contractor shall move the line level MPA amount on outpatient claims to the 2110 CAS segment on the ERA.					X				
10971.17	The Medicare Contractor shall report the MPA amount in the contractual obligation field on the Standard Paper Remit.					X				
10971.18	The Medicare contractor shall add the MPA amount as a separate field on the all claims and single claim reports in PC Print.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10971.19	The Medicare Contractor shall not report the value code to Benefits Coordination & Recovery Center (BCRC).					X				
10971.19.1	The Medicare contractor shall move the claim level MPA amount on inpatient claims to the 2320 CAS segment on the 837 BCRC					X				
10971.20	The Medicare contractor shall move the line level MPA amount on outpatient claims to the 2430 CAS segment on the 837 BCRC.					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): Adrienne Wiley, 410-786-3087 or adrienne.wiley@cms.hhs.gov , Katherine Sapra, 410-786-8969 or katherine.sapra@cms.hhs.gov

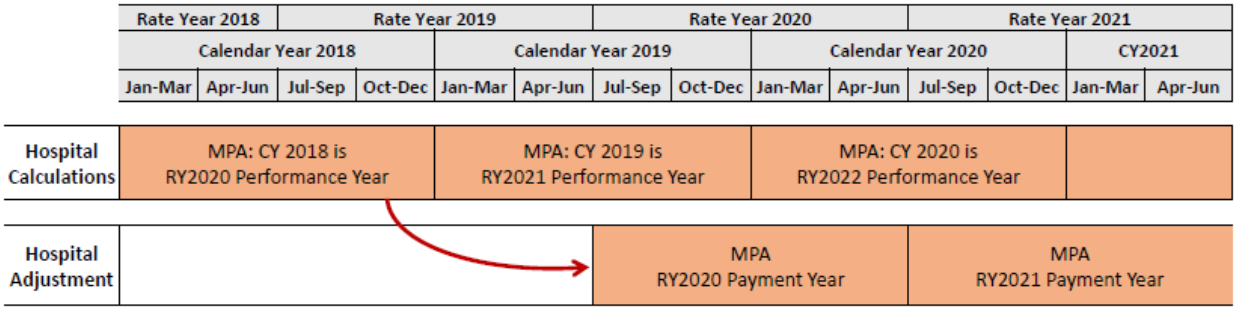
Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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: 1

Figure 1. MD TCOC Model MPA Implementation Timeline



Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

50.1 - Outpatient Provider Specific File
(Rev. 4257, Issued: 03-14-19, Effective: 07-01-19, Implementation: 07-01-19)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

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

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the 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.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).

49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Contractor #.
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 (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, contractors 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 Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration 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 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
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank) (blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	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 wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.

71-72	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. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs
74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.
75	X(1)	Filler	Blank.

76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.
85-89	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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	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 equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate 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
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.

106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.
118-122	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 due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
123-128	9V9(5)	Payment Model Adjustment (PMA)	Derived from payment model Technical Direction Letter.
129-133	*9V9999*	*Medicare Performance Adjustment (MPA)*	*Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).*
134-162	*X(29)*	*FILLER*	

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to system's capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Addendum A - Provider Specific File

(Rev. 4257, Issued: 03-14-19, Effective: 07-01-19, Implementation: 07-01-19)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></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; NOTE: 14 and 15 no longer valid, effective 10/1/12</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>
</table>

Data Element	File Position	Format	Title	Description
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
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

Data Element	File Position	Format	Title	Description
				06 Hospital Distinct Parts (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 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

Data Element	File Position	Format	Title	Description
				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 _ _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.

Data Element	File Position	Format	Title	Description
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.
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, 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 **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.

Data Element	File Position	Format	Title	Description
				Federal % / Facility% 1 — 25 / 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 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

Data Element	File Position	Format	Title	Description
				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.
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

Data Element	File Position	Format	Title	Description
				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 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	Per diem amount based on the interim

Data Element	File Position	Format	Title	Description
			Amount for Capital	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.
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.

Data Element	File Position	Format	Title	Description
				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.
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.

Data Element	File Position	Format	Title	Description
53	232-232	X	HRR Indicator	Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "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	*269-310*	*X(42)*	*Filler*	

190 – Payer Only Codes Utilized by Medicare

(Rev. 4257, Issued: 03-14-19, Effective: 07-01-19, Implementation: 07-01-19)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – M9 Not used by Medicare.

MA – GI Bleed.

MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH-MT – Not currently used by Medicare.

MZ – IOCE error code bypass

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48 - Date hospice face-to-face encounter was untimely

49 – Original Notice of Election (NOE) receipt date

Occurrence Span Codes

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – On Type of Bill 032x: HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.
On Type of Bills 081x 0r 082x: Number of High Routine Home Care Days - Days that fall within the first 60 days of a routine home care hospice claim.

63 – On Type of Bill 032x: HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

On Type of Bills 081x 0r 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Low volume hospital payment amount

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Accountable Care Organization reduction.

Q1 – Pioneer payment reduction

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – Reserved for future use

Q5 – EHR

Q6 – PQRS

Q7 – Q8 – Not used by Medicare

Q9 - Medicare Performance Adjustment (MPA)

QD – Device Credit

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU –Device credit with device offset

QV – Value-based purchasing adjustment amount

QW – Placeholder reserved for future use