

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 4308</b>	<b>Date: May 16, 2019</b>
	<b>Change Request 10971</b>

**Transmittal 4257, dated March 14, 2019, is being rescinded and replaced by Transmittal 4308, May 16, 2019 to add a note to business requirements 10971.4 and 10971.9, and to show correct chapter of Subsection 190 on the Transmittal. 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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	4/50.1/ Outpatient Provider Specific File
R	3/Addendum A/ Provider Specific File
R	1/190/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: 4308	Date: May 16, 2019	Change Request: 10971
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## **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.  $1\% / 3.33\% = 30\%$ ).

- **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)  $[\text{Total Cost of Care Benchmark} - \text{Total Cost of Care Performance}] / \text{Total Cost of Care Benchmark} * [\text{Maximum Revenue at Risk} / \text{Maximum Performance Threshold}] * \text{Quality Adjustment Score}$ . 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			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
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.  NOTE: The Medicare contractor shall apply the MPA value only if the reimbursement is positive after the beneficiary cost sharing deductions are applied.					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. <ul style="list-style-type: none"> <li>Report #710 - Inpatient Provider Specific Master File Maintenance Report</li> <li>Report #964 – Inpatient Provider Specific</li> </ul>					X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	Master File Maintenance Report <ul style="list-style-type: none"> <li>Report #967 - Inpatient Provider Specific Master File Maintenance Report</li> </ul>									
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.  NOTE: The Medicare contractor shall apply the MPA value only if the reimbursement is positive after the beneficiary cost sharing deductions are applied.					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					X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	layout as input. <ul style="list-style-type: none"> <li>REPORT # 709 -Outpatient Provider Specific Master File Maintenance Report</li> <li>REPORT # 961 -Outpatient Provider Specific Master File Maintenance Report</li> <li>REPORT # 968 -Outpatient Provider Specific Master File Maintenance Report</li> </ul>									
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.  <b>NOTE:</b> 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				



Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
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				
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			D M E M A C	C E D I
		A	B	H H H		
	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](mailto:adrienne.wiley@cms.hhs.gov) ,  
Katherine Sapra, 410-786-8969 or [katherine.sapra@cms.hhs.gov](mailto: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

	Rate Year 2018				Rate Year 2019				Rate Year 2020				Rate Year 2021	
	Calendar Year 2018				Calendar Year 2019				Calendar Year 2020				CY2021	
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
<b>Hospital Calculations</b>	MPA: CY 2018 is RY2020 Performance Year				MPA: CY 2019 is RY2021 Performance Year				MPA: CY 2020 is RY2022 Performance Year					
<b>Hospital Adjustment</b>									MPA RY2020 Payment Year				MPA RY2021 Payment Year	

# Medicare Claims Processing Manual

## Chapter 4 - Part B Hospital

### (Including Inpatient Hospital Part B and OPPS)

#### 50.1 - Outpatient Provider Specific File

*(Rev.4308, Issued: 05-16-19, 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 alphanumeric.

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 OPSS period. For subsequent OPSS 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	<p>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.</p> <p>(Termination date is the date on which the reporting contractor ceased servicing the provider in question).</p>
49	X(1)	Waiver Indicator	<p>Enter a “Y” or “N.”</p> <p>Y = waived (provider is not under OPPS)  For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS.</p> <p>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.</p>
50-54	9(5)	Intermediary Number	Enter the Contractor #.

55-56	X(2)	Provider Type	<p>This identifies providers that require special handling. Enter one of the following codes as appropriate.</p> <p>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</p>
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			<p>38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998</p> <p>40 Hospital Based ESRD Facility</p> <p>41 Independent ESRD Facility</p> <p>42 Federally Qualified Health Centers</p> <p>43 Religious Non-Medical Health Care Institutions</p> <p>44 Rural Health Clinics-Free Standing</p> <p>45 Rural Health Clinics-Provider Based</p> <p>46 Comprehensive Outpatient Rehab Facilities</p> <p>47 Community Mental Health Centers</p> <p>48 Outpatient Physical Therapy Services</p> <p>49 Psychiatric Distinct Part</p> <p>50 Rehabilitation Distinct Part</p> <p>51 Short-Term Hospital – Swing Bed</p> <p>52 Long-Term Care Hospital – Swing Bed</p> <p>53 Rehabilitation Facility – Swing Bed</p> <p>54 Critical Access Hospital – Swing Bed</p>
57	X(1)	Special Locality Indicator	<p>Indicates the type of special locality provision that applies.</p> <p>For End Stage Renal Disease (ESRD) facilities value “Y” equals low volume adjustment applicable.</p>
58	X(1)	Change Code For Wage Index Reclassification	<p>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.</p>
59-62	X(4)	Actual Geographic Location—MSA	<p>Enter the appropriate code for MSA, 0040–9965, or the rural area, <u>(blank) (blank)</u> 2-digit numeric State code, such as <u>  3  6</u> for Ohio, where the facility is physically located.</p>
63-66	X(4)	Wage Index Location—MSA	<p>The appropriate code for the MSA, 0040-9965, or the rural area, <u>(blank)(blank)</u> (2 digit numeric State code) such as <u>  3  6</u> 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.</p>
67-70	9V9(3)	Payment-to-Cost Ratio	<p>Enter the provider’s payment-to-cost ratio. Does not apply to ESRD Facilities.</p>

71-72	9(2)	State Code	<p>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.</p> <p>List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.</p>
73	X(1)	TOPs Indicator	<p>Enter the code to indicate whether TOPs applies or not.</p> <p>Y = qualifies for TOPs N = does not qualify for TOPs</p>
74	X(1)	Quality Indicator Field	<p>Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements.</p> <p>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.</p> <p>Blank = Hospital does not meet criteria.</p> <p>Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP):</p> <p>Blank = no reduction  1 = ½ percent payment reduction  2 = 1 percent payment reduction  3 = 1 ½ percent payment reduction  4 = 2 percent payment reduction</p> <p>* Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.</p>
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 ___ <u>3</u> <u>6</u> 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 ___ <u>3</u> <u>6</u> 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 ___ <u>3</u> 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.
<i>129-133</i>	<i>9V9999</i>	<i>Medicare Performance Adjustment (MPA)</i>	<i>Enter the MPA percentage calculated and published by the Centers for Medicare &amp; Medicaid Services (CMS).</i>
<i>134-162</i>	<i>X(29)</i>	<i>FILLER</i>	

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.4308, Issued: 05-16-19, Effective: 07-01-19, Implementation; 07-01-19)*

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

## **190 – Payer Only Codes Utilized by Medicare**

*(Rev.4308, Issued: 05-16-19, 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 Or 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 Or 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