CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2627	**Date: January 4, 2013**
	Change Request 8041

Transmittal 2539, dated August 31, 2012, is being rescinded and replaced by Transmittal 2627, dated January 4, 2013, to clarify hospital readmission and hospital value based purchasing values needed for the Provider Specific File and to add back in missing headings (New Technology Add-on, Hospital Readmissions Reduction Program, and Hospital Value Based Purchasing.) All other information remains the same.

SUBJECT: Fiscal Year (FY) 2013 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2013 update to the IPPS and LTCH PPS. Internet Only Manual updates are incorporated within this Recurring Notification.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/20.2.1/Medicare Code Editor (MCE)
R	3/20.3.1.3/Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009
N	3/20.3.1.4/Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2012
R	3/40.2.5/Repeat Admissions
R	3/40.3/Outpatient Services Treated as Inpatient Services
R	3/100.8/Replaced Devices Offered Without Cost or With a Credit
R	3/Addenda A-Provider Specific File

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2627	Date: January 4, 2013	Change Request: 8041

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes to the Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Prospective Payment System (PPS) for Long Term Care Hospitals (LTCHs) for FY 2013. The policy changes for FY 2013 were displayed in the Federal Register on August 01, 2012, with an anticipated publication date of August 31, 2012. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted.

B. Policy: MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG Grouper, Version 30.0, software package effective for discharges on or after October 1, 2012. The GROUPER assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The MCE Version 30.0 which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2012.

(for discharges occurring on or after October 1, 2012) – The Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation on or about August 03, 2012.

(for discharges occurring on or after October 1, 2012) – The MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation on or about August 03, 2012. Note that the version has been changed to match the Grouper.

Users of the MCE should be aware that there is a new edit effective October 1, 2012; Edit 19- Procedure inconsistent with length of stay. ICD-9-CM procedure code 9672 should only be coded on claims with a length of stay of four days or greater. The length of stay will be determined by counting the days between the from and through dates of the claim (minus any days in occurrence span code 74). Claims will be returned to provider indicating a length of stay conflict if less than 4 consecutive days. Systems changes were made to pass this information to the MCE.

IPPS FY 2013 Update

The FY 2013 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2012. Refer to Attachment-Tables, Table 1 for the FY 2013 IPPS Rates and Factors.

Post-acute Transfer and Special Payment Policy

There are no changes to the Post-acute and Special Post-acute payment policy or applicable DRGs for FY 2013.

See Table 5 of the FY 2013 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at the following link. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html.

New Technology Add-On

The following items are eligible for new-technology add-on payments in FY 2013:

- **Continue payments for the AutoLITT**- Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26 and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.
- **New for FY 2013- DIFICID**- Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868.
- **New for FY 2013- Zenith Fenestrated Graft**- Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.
- **New for FY 2013- Voraxaze**- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000.

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act and as extended by both the Affordable Care Act (ACA) and the Middle Class Tax Relief and Job Creation Act of 2012 is no longer in effect as of April 1, 2012.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A - Section 505, shows the IPPS providers that will be receiving a "special" wage index for FY 2013 (i.e., receive an out-commuting adjustment under section 505 of the MMA). **For any provider with a Special Wage Index from FY 2012, FIs and A/B MACs shall remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in this attachment.**

Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties

are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. **To ensure these hospitals counties (commonly referred to as "Lugar hospitals") are paid correctly under the IPPS, FIs and A/B MACs shall enter the urban Core Based Statistical Area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF, except for hospitals that waive Lugar redesignation for the out-migration adjustment (as discussed below in this instruction).**(Note: this may be different from the urban CBSA in the wage index CBSA field on the PSF for Lugar hospitals that are reclassified for wage index purposes.)

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. Refer to Attachment-Tables, Table 2 for a list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2013. (Note: this may be different from the CBSA in the wage index CBSA field on the PSF for such hospitals that are reclassified for wage index purposes.)

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

An urban hospital that reclassifies as a rural hospital is considered rural for all IPPS purposes.

The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the IPPS. Note, hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)). Please reference Table 9C of FFY 2013 Final rule.

Hospital Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

For FY 2013, Medicare contractors must update the Hospital Specific (HSP) amount in the PSF for all SCHs. The HSP amount must be updated from FY 2007 dollars to FY 2012 dollars by applying an update factor of 1.132312959, which represents the product of all of the annual market basket update (i.e., applicable percentage increase) and budget neutrality factors for FYs 2008 – 2012 and the rural floor restoration factor implemented in FY 2012 (see Attachment-Tables, Table 3), to the current HSP amount in the PSF before entering this final amount in the PSF with an effective date of 10/1/2012. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and will make future updates to the HSP amount beginning in FY 2013 and beyond.

Note, under current law the MDH program expires to the end of FY 2012 (that is, for discharges occurring before October 1, 2012), and therefore it is not necessary to update the HSP amount in the PSF for MDHs for FY 2013.

In addition, the HSP logic in Pricer has been modified to use the transfer-adjusted Federal rate payment amount, if applicable, when comparing the HSP rate payment amount to the Federal rate payment amount.

Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2012. Therefore, beginning in FY 2013, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (We note that, we have revised our SCH policy to allow MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program, as explained further in this instruction.)**Provider Types 14 and 15 are no longer valid beginning in FY 2013, and contractors shall update the PSF accordingly to reflect the appropriate provider type with an effective date of October 1, 2012.**

Sole Community Hospital (SCH) Clarification and Changes to Effective Dates for SCH classification

The regulations at §§ 412.92(b)(2) and (b)(3) address the effective dates of a classification as an SCH and the duration of this classification. Currently, a hospital's SCH classification status remains in effect without the need for reapproval unless there is a change in the circumstances under which the classification was approved. Section 412.92(b)(3) requires a hospital to notify the FI or MAC within 30 days of a change that could affect its classification as an SCH. The existing language at § 412.92(b)(3) only refers to a hospital becoming aware of a "change," because it deals specifically with a situation where a hospital was appropriately classified as an SCH because it had previously met the requirements to become an SCH. However, the regulations did not explicitly address the situation where a hospital never met the requirements to be classified as an SCH, but was incorrectly classified as an SCH.

In light of the fact that CMS found a number of providers who may have been classified as SCHs incorrectly, in the FY 2013 rule, CMS discusses the current authority to recoup any overpayments associated with the incorrect SCH status, consistent with the cost report reopening rules at § 405.1885, and to cancel the hospital's classification retroactively. As a result, CMS has the discretion to reopen cost reports within the 3-year reopening period and cancel a hospital's SCH status.

Additionally, effective October 1, 2012, if a hospital reports any factors or information to CMS that could have affected its initial classification as an SCH and CMS then determines that, based on the additional information, the hospital should not have qualified for SCH status, CMS will cancel SCH status effective beginning with 30 days from the CMS' date of determination.

Current regulations state that if a hospital qualifies for SCH status, that status is generally effective beginning 30 days after CMS' written notification of approval. Due to the expiration of the MDH provision on September 30, 2012, there may be a number of hospitals currently classified as MDHs under §412.108 that believe they qualify for classification as SCHs under § 412.92. In the FY 2013 IPPS/LTCH PPS final rule, we revised the regulations to provide for an exception to the effective date of SCH classification for any MDH that:

1. Applies for SCH status at least 30 days prior to the expiration of the MDH provision (that is, by August 31, 2012) and 2. Requests that SCH status be effective with the expiration of the MDH provision and the hospital is approved for SCH status.

The effective date of SCH status for those MDHs that comply with the application requirements and qualify for SCH status is the day following the expiration date of the MDH provision, that is, October 1, 2012.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2013

For FYs 2011 and 2012, the Affordable Care Act expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2013, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act. Therefore, as specified under the regulations at § 412.101, effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "subsection (d) hospital" and have less than 200 total discharges (including both Medicare and non Medicare discharges) during the fiscal year. For FY 2013 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

The FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The FI/MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. For FY 2013 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare

discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see § 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2013 (and subsequent years), a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest "subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/ MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2013, a hospital must meet both the discharge and mileage criteria (set forth at §412.101(b)(2)(i)).

For FY 2013, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2012, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2012 (through September 30, 2013). For requests for low-volume hospital status for FY 2013 received after September 1, 2012, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2013 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The FI/MAC is to notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as low-volume hospitals and the effective date of the determinations for FY 2013 by November 9, 2012. The notification may be sent via e-mail to Michele.Hudson@cms.hhs.gov and Maria.Navarro@cms.hhs.gov, and should include the hospital's name, CMS certification number (CCN), address (street, city, state and zip code), the number of total discharges and begin and end dates from the hospital's most recently submitted cost report, the distance to the nearest IPPS hospital (as well as that hospital's address: street, city, state and zip code) by which the hospital qualified for low-volume status, and the effective date of the low-volume hospital determination. For low-volume hospital requests received after September 1, 2012, FIs/MACs shall notify CMS Central Office as above within 15 days of the determination.

For discharges occurring during FY 2013, if a hospital qualifies as a low volume hospital, the existing low-volume indicator field on the PSF (position 74 – temporary relief indicator) must be updated by the FI/MAC to hold a value of 'Y'. In order to implement this policy for FY 2013, the Pricer will apply the 25 percent low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF . If a hospital qualified for the low-volume hospital payment adjustment in FY 2012 but no longer meets the low-volume hospital definition for FY 2013 (that is, does not meet either the discharge or mileage criteria in 412.101(b)(2)(i)), and therefore, the hospital is no longer eligible to receive a low-volume hospital payment adjustment in FY 2013,**the FI/MAC must update the low-volume indicator field on the PSF (position 74 - temporary relief indicator) to hold a value of 'blank'.**

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following Web site: www.qualitynet.org. This Web site is expected to be updated in September 2012. Should a provider later be

determined to have met the criteria after publication of this list, they will be added to the Web site, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2013 under the Hospital Inpatient Quality Reporting (IQR) Program are listed in Attachment B - Hospitals Not Receiving Annual Payment Update (APU) - FY 2013 of this CR.

For new hospitals, FIs and A/B MACs shall enter a '1' in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative. The FIs and A/B MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following: • State Code • Medicare Accept Date • Provider Name • Contact Name (if available) • Provider ID number • Telephone Number

Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154 as established in the FY 2013 IPPS/LTCH PPS final rule).

In the FY 2012 IPPS/LTCH PPS final rule, CMS finalized the readmission measures for Acute Myocardial Infarction, (AMI), Heart Failure (HF) and Pneumonia (PN) and the calculation of the excess readmission ratio, which is used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio is based on discharges occurring during the 3 year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS/ LTCH PPS Final Rule.

In the FY 2013 IPPS final rule, CMS finalized that "subsection (d) hospitals" are subject to the Hospital Readmissions Reduction Program, which excludes Puerto Rico hospitals. In addition, CMS has exempt Maryland hospitals from the Hospital Readmissions Reduction Program for FY 2013. In the FY 2013 IPPS final rule, CMS established the methodology to calculate the hospital readmissions adjustment factor, what portion of the IPPS payment will be used to calculate the readmissions adjustment amount and CMS has established a process for hospitals to review their readmissions information and submit corrections to the information before the readmission rates are to be made public.

For FY 2013, the readmissions adjustment factor is the higher of a ratio or 0.99 (-1 percent). The methodology to calculate the ratio is discussed in the FY 2013 IPPS final rule. The readmission adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH, outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under

the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2013 (such as Maryland hospitals), will have a readmission adjustment factor of 1.0000. For FY 2013, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9900.

The newly added Hospital Readmissions Reduction Program participant (HRR Participant) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF for FY 2013 must be updated by the FI/MAC with an effective date of October 1, 2012. The Hospital Readmissions Reduction Program adjustment factors for FY 2013 can be found in Table 15 of the FY 2013 IPPS final rule, which is available on the Internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html.

- If a provider has a readmissions adjustment factor on Table 15 that is equal to 1.0000, then Medicare contractors shall input a value of '2' in the HRR Participant field and leave the HRR Adjustment field blank.
- If a provider has a readmissions adjustment factor on Table 15 that is less than 1.0000, then Medicare contractors shall input a value of '1' in the HRR Participant field and enter the decimal point and the **4 decimal place values** of the readmissions adjustment factor in Table 15 into the HRR Adjustment field in FISS. (For example, if the readmissions adjustment factor in Table 15 is 0.9963, then '.9963' should be entered in the HRR Adjustment field in FISS.)
- If a provider is not listedon Table 15, then Medicare contractors shall input a value of '0' in the HRR Participant field and leave the HRR Adjustment field blank.

Note: Although Maryland hospitals are exempt from the payment adjustment under the Hospital Readmissions Reduction Program for FY 2013, a readmissions adjustment factor of 1.0000 (that is no adjustment) is shown for Maryland hospitals in Table 15. Therefore, follow the instructions above for the PSF for Maryland hospitals.

Note: Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program and therefore are not listed in Table 15. Therefore, follow the instructions above for the PSF for Puerto Rico hospitals.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program results in adjustments to base operating DRG payment amounts for discharges from subsection (d) hospitals, for discharges beginning in FY 2013. CMS has excluded Maryland hospitals from the Hospital VBP Program for the FY 2013 program year. CMS will not implement the FY 2013 payment adjustments under the Hospital VBP Program until January 2013. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.160 through §412.162).

Under the Hospital VBP Program, CMS will reduce base operating DRG payment amounts for subsection (d) hospitals by the applicable percent, beginning with discharges occurring in FY 2013. The applicable percent for payment reductions for FY 2013 is 1.0 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS will calculate a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS will then use a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS,

the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS will calculate a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSes and submit requests for corrections to the information before it is made public.

For FY 2013, as noted above, CMS will not implement the base operating DRG payment amount reductions or the value-based incentive payment adjustments until January 2013. Claims for discharges occurring in FY 2013 that are paid prior to this January 2013 implementation will be reprocessed by CMS as quickly as practicable. CMS will provide the claims processing contractors with a file containing the value-based incentive payment adjustment factors via Technical Direction Letter (TDL).

Upon receipt of this file, the claims processing contractors must update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital VBP Program and the claims processing contractors must update the newly-added Hospital VBP Program adjustment field (VBP Adjustment) to input the value-based incentive payment adjustment factor, according to the timeframe included in the forthcoming TDL. Note that the values listed in Table 16 of the IPPS/LTCH PPS Final Rule are proxy values. Until CMS issues final values, contractors shall enter 'N' in the VBP Participant field.

Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled Payments for Care Improvement Initiative (BPCI) Model 1

CMS is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model will propose a discount percentage which will be applied to payment for all participating hospitals' Diagnosis Related Groups (DRG) over the lifetime of the initiative. Participating hospitals may gainshare with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at: http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html.

For hospitals participating in Model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG (as defined earlier in this change request). IME, DSH, and outlier payments will be calculated based on the nondiscounted base payments.

A list of participating hospitals and the applicable discount will be issued at a later date to the FIs/MACs to be loaded into the PSF. The Pricer has been modified to perform this payment calculation when demo code

61 is present. Demo codes are a new claim input to Pricer.

Provider Specific File (PSF)

The PSF-required data elements for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, but you must update all applicable fields for IPPS hospitals effective October 1, 2012, or effective with cost reporting periods that begin on or after October 1, 2012, or upon receipt of an as-filed (tentatively) settled cost report. Pricer requires a PSF record with a 10/1 effective date.

Tables 8a and 8b contain the FY 2013 Statewide average operating and capital cost-to-charge ratios, respectively. Tables 8a and 8b are available on the internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html.

Per the regulations at 42 CFR section 412.84(i)(3), for FY 2013, Statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18). 2. Hospitals whose operating CCR is in excess 1.146 or capital CCR is in excess of 0.166 (referred to as the operating CCR ceiling and capital CCR ceiling, respectively). 3. Hospitals for which the FI or MAC is unable to obtain accurate data with which to calculate an operating and/or capital CCR. Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2 of chapter 3 of the claims processing manual. Provider Types (PSF data element 9) 14 and 15 are no longer valid beginning in FY 2013 (with the expiration of the MDH program as noted below). Contractors shall determine the appropriate provider type and update the PSF accordingly with an effective date of October 1, 2012.

In addition, we have added the five following new PSF data elements:

1. VBP Participant

* 'Y' = provider is subject to the Value-Based Purchasing (VBP) program; or * 'N' = provider is not subject to the Value-Based Purchasing (VBP) program

2. VBP Adjustment

3. HRR Participant

* '2' = provider is subject to the Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000

* '1' = provider is subject to the Hospital Readmissions Reduction program

* '0' = provider is not subject to the Hospital Readmissions Reduction program

4. HRR Adjustment (Hospital Readmissions Reduction program adjustment factor from Table 15 of the Addendum to the final rule)

5. Bundle Model 1 Discount (discount percentage)

LTCH PPS FY 2013 Update

See Attachments-Tables, Table 4 for FY 2013 LTCH PPS Rates and Factors

The LTCH PPS Pricer has been updated with the Version 30.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2012, and on or before September 30, 2013.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2012, or effective with cost reporting periods that begin on or after October 1, 2012, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8c contains the FY 2013 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments. Table 8c is available on the internet at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2013, Statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18). 2. Hospitals whose LTCH total CCR is in excess of 1.212 (referred to as the total CCR ceiling). 3. Any hospital for which data to calculate a CCR is not available. Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the claims processing manual.

Short Stay Outlier (SSO) Payment Formula

The statutory 5-year moratorium on the application of the "IPPS comparable per diem amount" option under the short-stay outlier (SSO) payment adjustment expires for discharges beginning on or after December 29, 2012. With the expiration of the moratorium the existing SSO payment formula is revised for those cases where the patient's covered length of stay (LOS) is less than or equal to the "IPPS comparable threshold" for the MS-DRG to which the case is assigned. The "IPPS-comparable threshold" is defined as one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (as shown in Table 11 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule and available on the Internet). If the covered LOS at the LTCH is within the "IPPS-comparable threshold", the "IPPS comparable per diem amount" (capped at the full "IPPS comparable amount") option will replace the "blend amount" option in the current SSO payment formula.

For a SSO discharge occurring on or after December 29, 2012, the Medicare payment will be based on the least of the following:

- 100 percent of the estimated cost of the case.
- 120 percent of the MS-LTC DRG specific per diem amount multiplied by the covered length of stay of the particular case.
- The full MS-LTC-DRG per diem amount.
- Comparing the covered length of stay for the SSO case and the "IPPS comparable threshold," one of the following:

(a) A blend of the 120 percent of the MS-LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount, for cases where the covered length of stay for the SSO case is greater than the "IPPS comparable threshold". (b) An amount comparable to the IPPS comparable per diem amount, if the covered length of stay for an SSO case is equal to or less than one standard deviation from the geometric average length of stay for the same MS DRG under the IPPS (the "IPPS comparable threshold").

The IPPS comparable per diem amount is determined by the same methodology as the IPPS comparable per diem portion of the current "blend amount" option.

For SSO cases where the covered LOS exceeds the "IPPS comparable threshold," payment is made under the existing SSO policy, as specified above.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Core-Based Statistical Area (CBSA)-based Labor Market Area Updates

There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2013. The CBSAs definitions and codes that will continue to be effective October 1, 2012 can be found in Table 12A listed in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, which is available on our website.

Additional LTCH PPS Policy Changes for FY 2013

The 5-year statutory moratorium on the full-implementation of the "25 percent threshold" payment adjustment for LTCH discharges admitted from individual referring hospitals expires for LTCH cost reporting periods beginning on or after July 1, 2012 or October 1, 2012, as applicable. In the FY 2013 IPPS/LTCH PPS final rule, CMS extended the moratorium on the implementation of the "25 percent threshold" payment policy effective for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012 and before October 1, 2012, CMS also provided a supplemental moratorium effective for discharges occurring on or after October 1, 2012 and through the end of the cost reporting period. For additional details, refer to the discussion in the FY 2013 IPPS/LTCH PPS final rule.

The 5-year statutory moratorium on the development of new LTCHs and LTCH satellite facilities and an increase in number of LTCH beds initially provided in section 114(d) of the MMSEA, will expire on December 29, 2012.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8041.1	FISS shall install and pay claims with the FY 2013 IPPS Pricer for discharges on or after October 1, 2012**.**							X				
8041.2	FISS shall install and pay claims with the FY 2013 LTCH Pricer for discharges on or after October 1, 2012.							X				
8041.3	FISS shall install and edit claims with the MCE version							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	30.0 and GROUPER version 30.0 software with the implementation of the FY 2013 October quarterly release.											
8041.4	FISS shall establish yearly recurring hours to allow for updates to the list of ICD-9-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** For FY2013, procedure code 00.95 was the only new code added; therefore, there is no change to the POA listing for FY 13.							X				
8041.5	CWF shall update edit 7272 with the post-acute care (PAC) MS-DRGs listed in Table 5 of the IPPS Final Rule (link on page 2 of this CR) effective for discharges on or after 10/01/2012 (includes special pay). **NOTE:** There are no changes to the PAC MS-DRGs for FY2013										X	
8041.6	Contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X			X							
8041.7	Contractors shall update ALL relevant portions of the PSF in accordance with this CR by October 9, 2012.	X			X							
8041.7.1	Contractors shall update the PSF for CBSA and special wage index changes per the policy sections of this CR.	X			X							
8041.7.2	Contractors shall notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges occurring in FY 2013 by November 9, 2012. Contractors shall also notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro of IPPS hospitals qualified as low-volume hospitals after September 1, 2012, within 15 days of the determination.	X			X							
8041.8	Contractors shall be aware of the manual updates included within this CR.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8041.9	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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): Sarah Shirey-Losso, 410-786-0187 or sarah.shirey-losso@cms.hhs.gov , Cami DiGiacomo, 410-786-5888 or cami.digiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

ATTACHMENT(S): 3

CMS Certification Number (CCN)	Reclassified for FY 2013
010008	0.7436
010010	0.7397
010012	0.7248
010015	0.7126
010021	0.7133
010027	0.7102
010032	0.7380
010038	0.7485
010047	0.7337
010049	0.7102
010052	0.7196
010061	0.7646
010078	0.7485
010091	0.7126
010109	0.7662
010110	0.7521
010125	0.7496
010128	0.7126
010129	0.7224
010138	0.7160
010146	0.7485
010150	0.7337
010164	0.7259
030067	1.0857
040019	0.7754
040047	0.7538
040067	0.7547
050007	1.6119
050069	1.2313
050070	1.6119
050113	1.6119
050133	1.2513
050168	1.2313
050224	1.2313
050226	1.2313
050230	1.2313
050264	1.6145
050289	1.6119
050325	1.2329
050348	1.2313
050426	1.2313
050444	1.2900

050526	1.2313
050541	1.6119
050543	1.2313
050548	1.2313
050551	1.2313
050567	1.2313
050570	1.2313
050580	1.2313
050589	1.2313
050603	1.2313
050609	1.2313
050678	1.2313
050744	1.2313
050745	1.2313
050746	1.2313
050747	1.2313
050754	1.6119
050768	1.2313
050769	1.2313
060003	1.0367
060027	1.0367
060103	1.0367
060116	1.0367
070020	1.1830
070021	1.1929
110029	0.9510
110100	0.8349
110101	0.7598
110142	0.7720
110146	0.7836
110150	0.7737
110205	0.7994
130066	0.9423
140001	0.8715
140026	0.8696
140116	1.0418
140167	0.9163
140176	1.0418
140234	0.8696
150022	0.8580
150072	0.8422
160013	0.8399
160032	0.8556
170150	0.8078
180064	0.8125
180066	0.8447
180070	0.8036

180079	0.8090
190034	0.7997
190044	0.8056
190050	0.7897
190053	0.7948
190054	0.7911
190088	0.8119
190099	0.7949
190106	0.7923
190116	0.7915
190133	0.7923
190140	0.7871
190145	0.7892
190184	0.7890
190190	0.7890
190257	0.7895
190303	0.8078
210001	0.9536
210023	1.0032
210028	0.8970
210043	1.0032
210061	0.8923
220002	1.3439
220011	1.3439
220049	1.3439
220063	1.3439
220070	1.3439
220082	1.3439
220084	1.3439
220098	1.3439
220101	1.3439
220105	1.3439
220171	1.3439
220175	1.3439
230005	0.8786
230015	0.8611
230047	0.9628
230075	0.9754
230093	0.8385
230195	0.9628
230217	0.9754
230227	0.9628
230264	0.9628
240018	0.9977
240044	0.9787
240101	0.9201
240117	0.9669

250128	0.7986
250162	0.8428
260059	0.7973
260160	0.8088
260163	0.8023
280077	0.8749
300011	1.1534
300012	1.1534
300017	1.2045
300020	1.1534
300023	1.2045
300029	1.2045
300034	1.1534
310015	1.1366
310017	1.1366
310050	1.1366
310129	1.1366
320011	0.9120
330027	1.3052
330033	0.8482
330047	0.8328
330106	1.3052
330132	0.8402
330167	1.3052
330175	0.8522
330181	1.3052
330182	1.3052
330191	0.8460
330198	1.3052
330222	0.8681
330225	1.3052
330259	1.3052
330276	0.8292
330331	1.3052
330332	1.3052
330372	1.3052
340024	0.8404
340038	0.8590
340039	0.8351
340069	0.9383
340073	0.9383
340114	0.9383
340133	0.8699
340151	0.8345
340173	0.9383
340186	0.8590
360002	0.8550

360040	0.8903
360044	0.8585
360058	0.8528
360070	0.8627
360071	0.8529
360084	0.8627
360096	0.8469
360107	0.8621
360131	0.8627
360151	0.8627
360156	0.8621
360356	0.8621
370015	0.8212
370023	0.7895
370065	0.7926
370072	0.7897
370083	0.7838
370100	0.7848
370156	0.7920
370169	0.7997
370172	1.4521
370214	0.7920
390008	0.8331
390031	0.8419
390039	0.8327
390052	0.8338
390056	0.8342
390112	0.8327
390117	0.8328
390150	0.8325
390173	0.8340
390201	0.9265
390236	0.8335
420005	0.8300
420019	0.8457
420027	0.9070
420043	0.8462
420053	0.8398
420054	0.8302
420055	0.8319
420062	0.8384
420098	0.8316
430048	1.0353
430094	1.0353
440007	0.7793
440008	0.7863
440016	0.7694

440031	0.7637
440033	0.7647
440035	0.8360
440047	0.7802
440051	0.7659
440057	0.7639
440060	0.7802
440070	0.7674
440081	0.7676
440084	0.7644
440109	0.7653
440115	0.7802
440137	0.8219
440148	0.7856
440174	0.7849
440180	0.7647
440181	0.7920
440182	0.7694
450090	0.8783
450163	0.8188
450192	0.8388
450210	0.8200
450236	0.8498
450270	0.8388
450370	0.8323
450438	0.8323
450451	0.8596
450460	0.8128
450497	0.8588
450539	0.8211
450565	0.8510
450573	0.8205
450597	0.8076
450615	0.8123
450641	0.8588
450698	0.8336
450755	0.8647
450813	0.8103
460001	0.8986
460013	0.8986
460023	0.8986
460043	0.8986
460052	0.8986
490084	0.8247
490110	0.8325
500019	1.0332
510012	0.7494

520009	0.9452
520035	0.9610
520044	0.9610
520057	0.9693
520076	0.9644
520088	0.9509
520095	0.9693
520102	1.0024
520160	0.9452
670071	0.9489

Table 1--FY 2013 IPPS Rates and Factors

Standardized Amount Applicable Percentage Increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Hospital Specific Applicable Percentage Increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Common Fixed Loss Cost Outlier Threshold	$21,821
Federal Capital Rate	$425.49
Puerto Rico Capital Rate	$207.25
Outlier Offset-Operating National	0.948999
Outlier Offset-Operating Puerto Rico	0.94476
SCH Budget Neutrality Factor	0.998431
SCH Documentation and Coding Adjustment Factor	0.9480

Operating Rates

Rates with Full Market Basket and Wage Index > 1	
National Labor Share	$3,679.95
National Non Labor Share	$1,668.81
PR National Labor Share	$3,679.95
PR National Non Labor Share	$1,668.81
Puerto Rico Specific Labor Share	$1,564.17
Puerto Rico Specific Non Labor Share	$954.62
Rates with Full Market Basket and Wage Index < or = 1	
National Labor Share	$3,316.23
National Non Labor Share	$2,032.53
PR National Labor Share	$3,316.23
PR National Non Labor Share	$2,032.53
Puerto Rico Specific Labor Share	$1,561.65

Puerto Rico Specific Non Labor Share	$957.14
Rates with Reduced Market Basket and Wage Index > 1	
National Labor Share	$3,607.65
National Non Labor Share	$1,636.02
PR National Labor Share	$3,679.95
PR National Non Labor Share	$1,668.81
Puerto Rico Specific Labor Share	$1,564.17
Puerto Rico Specific Non Labor Share	$954.62
Rates with Reduced Market Basket and Wage Index < or = 1	
National and PR National Labor Share	$3,251.08
National and PR National Non Labor Share	$1,992.59
PR National Labor Share	$3,316.23
PR National Non Labor Share	$2,032.53
Puerto Rico Specific Labor Share	$1,561.65
Puerto Rico Specific Non Labor Share	$957.14

Table 2- Hospitals Waiving Lugar Redesignation for the Out-Migration Adjustment

Medicare CCN	Provider Name
070021	**Windham Community Memorial Hospital**
390031	**Schuylkill Medical Center- East Norwegian Street**
520102	**Aurora Lakeland Medical Center**

Table 3- Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

Fiscal Year	Applicable Percentage Increase (Market Basket Update)	Budget Neutrality Factor	Rural Floor Restoration Factor
2008	1.0330	0.995743	N/A
2009	1.0360	0.998795	N/A
2010*	1.0185	0.997935	N/A
2011	1.0235	0.996731	N/A
2012	1.0190	0.997903	1.009

* Factors for FY 2010 reflect the implementation of the provisions of the ACA.

Table 4- FY 2013 LTCH PPS Rates and Factors

Federal Rate for discharges from 10/1/12 through 12/28/12	$40,915.95
Federal Rate for discharges from 12/29/12 through 9/30/13	$40,397.96
High Cost Outlier Fixed-Loss Amount	$15,408
Labor Share	63.096%
Non-Labor Share	36.904%

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev2627, 01-04-13.)

20.2.1 - Medicare Code Editor (MCE)

(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

A. General

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

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

Code Edits - Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

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

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

B. Implementation Requirements

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

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

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

- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

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

C. Bill System/MCE Interface

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

- Age;
- Sex;
- Discharge status;
- Diagnosis (25 maximum – principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

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

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

D. Processing Requirements

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

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI/MAC returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The hospital

must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. E-Code as Principal Diagnosis

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

3. Duplicate of PDX

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

4. Age Conflict

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

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

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

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The list of diagnoses that are acceptable for each age category can be located in the most current version of the MCE, which is posted as a data file under the Acute Inpatient PPS webpage. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/01_overview.asp
If the FI/MAC edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI/MAC edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis or patient's age before returning the bill.

5. Sex Conflict

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

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

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

The MCE contains listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

6. Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The MCE contains listings of ICD-9-CM diagnoses identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

7. Nonspecific Principal Diagnosis

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

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign Hypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

The MCE contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

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

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, Vl73 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." The A/B MAC or the FI may review claims with diagnosis V571, V5721, V5722, V573, V5789, and V579 and a secondary diagnosis. A/B MACs or FIs may choose to review as a principal diagnosis if data analysis deems it a priority.

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

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

10. Nonspecific O.R. Procedures

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

11. Noncovered O.R. Procedures

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

12. Open Biopsy Check

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

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI/MAC requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

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

13. Bilateral Procedure

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

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

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

14. Invalid Age

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

15. Invalid Sex

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

16. Invalid Discharge Status

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

17. **Invalid Discharge Date**

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

18 **– Limited Coverage**

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

19 - Procedure inconsistent with length of stay

Effective October 1, 2012, the following procedure code should only be coded on claims with a length of stay of four days or greater.

9672 Continuous invasive mechanical ventilation for 96 consecutive hours or more

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

(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

Observation Days

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

Labor and Delivery Patient Days

For cost reporting periods beginning on or after October 1, 2009, we will include in the Medicare disproportionate patient percentage (DPP) patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a "maternity suite" in which labor, delivery, recovery and postpartum care all take place in the same room. Prior to October 1, 2009, patient days associated with beds used for ancillary labor and deliver

were not counted in the DPP. However, for cost reporting periods beginning on or after October 1, 2009, *but before cost reporting periods beginning on or after October 1, 2012*, if a patient, admitted to the hospital as an inpatient, occupies an ancillary bed for labor and delivery, the patient days associated with the ancillary labor/delivery services will be counted in the DPP. *For cost reporting periods beginning on or after October 1, 2009 but before cost reporting periods beginning on or after October 1, 2012,* this policy applies only to counting patient days, and does not change the policy of determining the number of available beds in 42 CFR 412.106(a). Beds associated with ancillary labor/delivery services are not included in the available bed day count.

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

20.3.1.4 – Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2012
(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

Labor and Delivery Bed Days
Effective for cost reporting periods beginning on or after October 1, 2012, we will include bed days associated with ancillary labor/delivery services to determine the number of beds in 42 CFR 412.105(b), which is cross-referenced in 42 CFR 412.106(a)(1)(i) for the purposes of determining the DSH payment adjustment. Bed days associated with ancillary labor/delivery services will be included to determine the number of beds for DSH and IME. For cost reporting periods beginning before October 1, 2012, bed days associated with ancillary labor and delivery services were not counted in the available bed day count for DSH and IME.

40.2.5 - Repeat Admissions
(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is

indicated following diagnostic tests but cannot begin immediately. Institutional providers *must* not use the leave of absence billing procedure when the second admission is unexpected.

The A/B MACs or FIs may choose to review claims if data analysis deems it a priority. AB/MACs FIs will review the claim selected, based on the medical record associated with that claim and make a payment determination on that claim. They will then refer the claim to the QIO, in accordance with IOM 100-08, chapter 6, §6.5.7.

The QIOs may review acute care hospital admissions occurring within 30 days of discharge from an acute care hospital if both hospitals are in the QIO's jurisdiction and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.

NOTE: The QIO's authority to review and to deny readmissions when appropriate is **not** limited to readmissions within 30 days. The QIO has the authority to deny the second admission to the same or another acute PPS hospital, no matter how many days elapsed since the patient's discharge.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one DRG payment is made. The A/B MAC or the FI do not consider leave of absence bills as two admissions. It may select such bills for review for other reasons.

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Services rendered by other entities during a combined stay must be paid by the acute care PPS hospital. The acute care PPS hospital is responsible for the other entity's services per common Medicare practice.

NOTE: Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital.

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Upon the request of a A/B MACs or the FIs, hospitals must submit medical records pertaining to the readmission.

For Non-PPS acute care hospitals, such as Maryland waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month. However, the original bill would have to be adjusted to change the patient status code to a 30 (still a patient). Subsequent monthly bills for this admission would be billed as interim bills, 112, 113 or 114.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

A Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for FI requirements for detecting duplicate claims in such cases.

B Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children’s hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, outpatient diagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

0254 -	Drugs incident to other diagnostic services
0255 -	Drugs incident to

	radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341, 0343 -	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X -	CT scan
0371 -	Anesthesia incident to Radiology
0372 -	Anesthesia incident to other diagnostic services
040X -	Other imaging services
046X -	Pulmonary function
0471 -	Audiology diagnostic
0481, 0489-	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes *93451-93464,* 93503, 93505, *93530-93533,* 93561*-93568, 93571-93572, G0275, and G0278* diagnostic
0482-	Cardiology, Stress Test
0483-	Cardiology, Echocardiology
053X -	Osteopathic services
061X -	MRT
062X -	Medical/surgical supplies, incident to radiology or other diagnostic services
073X -	EKG/ECG
074X -	EEG
0918-	Testing- Behavioral Health
092X -	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from

IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991 *and Before June 25, 2010*)

Nondiagnostic outpatient services that are related to a *beneficiary's* hospital admission and that are provided by the *admitting* hospital, or by an entity *that is* wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the *beneficiary's* admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The FI shall assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B. This provision applies only when the beneficiary has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Hospitals must not include on a claim for an inpatient admission any outpatient nondiagnostic services that are not payable under Part B. For example, oral medications that are considered self-administered drugs under Part B are not payable under the outpatient prospective payment system (OPPS) and must not be bundled on an inpatient claim for purposes of the 3-day (or 1-day) payment window policy.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore, outpatient nondiagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, admission-related outpatient nondiagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any admission-related outpatient nondiagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient nondiagnostic services that are included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient nondiagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient nondiagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

*An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.*

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, admission-related outpatient nondiagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008 *and before June 25, 2010*, CWF will reject *claims for* nondiagnostic services when the following is met:

1) There is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay, and

2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

D Other Preadmission Services *(Effective for Services Furnished On or After June 25, 2010)*

Beginning on or after June 25, 2010, the definition of "other services related to the admission" (i.e., admission-related outpatient "nondiagnostic" services) is revised for purposes of the 3-day (or 1-day) payment window policy. Except for the following changes, the other requirements in section 40.3.C continue to be applicable.

For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

Hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient diagnostic services and all preadmission outpatient nondiagnostic services that meet the above requirements. For purposes of the Present on Admission Indicator (POA), even if the outpatient services are bundled with the inpatient claim, hospitals shall code any conditions the patient has at the time of the order to admit as an inpatient as POA irrespective of whether or not the patient had the condition at the time of being registered as a hospital outpatient. In combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD-9-CM codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window.

Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission and are covered by Part B may be separately billed to Part B. Hospitals must maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission.

Effective for dates of service on or after June 25, 2010, CWF will reject outpatient claims for nondiagnostic services when the following occurs:

1) Condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") is not included on the outpatient claim, and

2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

100.8 – Replaced Devices Offered Without Cost or With a Credit

(Rev2627, Issued 01-04-13, Effective 10-01-12, Implementation 10-01-2012.)

Background

To identify and track claims billed for replacement devices, CMS issued CR 4058 on November 4, 2005. This CR provided instructions for billing and processing claims with the following condition codes:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

Policy

Beginning with discharges on or after October 1, 2008, CMS reduces Medicare payment when a replacement device is received by the hospital at a reduced cost or with a credit that is 50 percent or greater than the cost of the device, and when the assigned MS-DRG for the claim is one of the MS-DRGs applied to this policy.

For a list of MS-DRGs for which this policy applies to, please see the IPPS Final Rule.

This adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay.

Billing Procedures (Discharges on or after October 1, 2008)

To correctly bill for a replacement device that was provided with a credit or no cost, hospitals must use the combination of condition code 49 or 50, along with value code FD. The condition code 49 or 50 will identify a replacement device while value code FD will communicate to

Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.

Payment (Discharges on or after October 1, 2008)

Medicare deducts the partial/full credit amount, reported in the amount for value code FD, from the final IPPS reimbursement when the assigned MS-DRG is one of the MS-DRGs applied to this policy.

Reminder about Charging for Recalled Devices

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a credit for a replacement medical device, the charges to Medicare should also be appropriately reduced.

Addendum A - Provider Specific File

(Rev.)

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

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; 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>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting FI 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 FI, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing FI. Likewise, if the provider identification number changes, the FI must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will

Data Element	File Position	Format	Title	Description
				no longer be used. Instead, FIs 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

Data Element	File Position	Format	Title	Description
				46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, FIs 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 FI 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	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank)

Data Element	File Position	Format	Title	Description
			Location - MSA	(blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. *Eff. 10/1/12, MDHs are no longer valid provider types.*
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/07_DataFiles.asp#TopOfPage
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. FIs 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 FI is responsible

Data Element	File Position	Format	Title	Description
				for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
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 FI billing file, i.e., PS&R record. For hospitals for which the FI 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.

Data Element	File Position	Format	Title	Description
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 as of FY92.
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
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	Enter the appropriate code for the CBSA

Data Element	File Position	Format	Title	Description
			Geographic Location Core-Based Statistical Area (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)	Standardized Amount 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. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a “1” or “2.”
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through	Per diem amount based on the interim

Data Element	File Position	Format	Title	Description
			Amount for Organ Acquisition	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. 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

Data Element	File Position	Format	Title	Description
				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 FI 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 FI 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*

Data Element	File Position	Format	Title	Description
				field must = N.
52	*220-231*	*9V9(11)*	*VBP Adjustment*	*Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.*
53	*232-232*	*X*	*HRR Indicator*	*Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "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	*233-236*	*V9(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	*237-238*	*V99*	*Bundle Model 1 Discount*	*Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).*
56	*239-260*	*X(22)*	*Filler*	