# Medicare Claims Processing Manual
## Chapter 3 - Inpatient Hospital Billing

### 20.2.3.1 - Provider-Specific File
***(Rev.3373, Issued: 10-14-15, Effective 10-01-15, Implementation10-05-15)***

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. *Updates are published annually or quarterly, as needed, to notify A/B MACs of any changes to payment systems requiring updates to the PSF.*

The *A/B MACs* maintain the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the *A/B MAC* prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the *A/B MAC* makes an additional record showing the effective date of the change.

The format and data required by the PRICER program and by the provider-specific file is found in Addendum A.

The *A/B MACs* submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), SNFs, and hospices, including those in Maryland. Regional home health *A/B MACs (HH)* submit a file of provider specific data for all home health agencies. *A/B MACs* serving as the audit *A/B MAC* for hospital based HHAs do not submit a file of provider specific data for HHAs.

The *A/B MACs* create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

**NOTE:** *A/B MACs* submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the *A/B MAC* may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the *A/B MAC* may exclude the October 1 CO-required changes from the file submitted by October 9. The *A/B MAC* includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

**A. PPS Hospitals**

The *A/B MACs (A)* submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

**B. Non-PPS Hospitals and Exempt Units**

The *A/B MACs (A)* create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

**C. Hospice**

The *A/B MACs (A)* create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all hospices. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

**D. Skilled Nursing Facility (SNF)**

The *A/B MACs (A)* create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. The *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all SNFs. Data elements 33 and 38 are required if there is a special wage index. Effective October 1, 2005, through September 30, 2006, data elements 33 and 38 are required since there is a special wage index.

**E. Home Health Agency (HHA)**

The *A/B MACs (HH)* create a provider specific history file using the following data elements for each HHA. Regional home health *A/B MACs (HH)* submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not

completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

**F. Inpatient Rehabilitation Facilities (IRFs)**

The *A/B MACs (A)* create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 18, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all IRFs. Data elements 17, 33, 38, and 49 are required if applicable to the IRF.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

**G. Long Term Care Hospital (LTCH)**

The *A/B MACs (A)* create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Effective July 1, 2005, data element 35 is required. Data elements 33 and 38 are optional and may be populated if needed. Data elements 12, 13, and 14 are no longer applicable.

Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

**H. Inpatient Psychiatric Facilities (IPF)**

The *A/B MACs (A)* create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005.

The *A/B MACs (A)* submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 17, 18, 19, 21, 22, 23, 25, 33, 35, 38, and 48 are required. All other data elements are optional for this provider type. Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element

21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

Effective July 1, 2006, data element 13 is no longer required. Data elements 33 and 38 are optional and may be populated if needed.

Effective October 1, 2013, data element 34 (Hospital Quality Indicator) is required.

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

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. *A/B MACs* must set up an NDM transfer from the *A/B MACs* system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the *A/B MAC's* 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See **Addendum A** for the Provider Specific File record layout and description.

## 20.3.4 – Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond

***(Rev.3373, Issued: 10-14-15, Effective 10-01-15, Implementation10-05-15)***

The IPPS changes for FY 2004 were published in the Federal Register on August 1, 2003. All changes are effective for hospital discharges occurring on or after October 1, 2003. Additional changes were listed in a Correction Notice to the Federal Register on October 6, 2003, and a One Time Notification (Pub. 100-20, Transmittal 16, published on October 31, 2003).

*Fiscal year* changes to the inpatient prospective payment system occur every October. Specific instructions will be published shortly after the publication of the IPPS Final Rule each year. *In addition, other changes to the inpatient prospective payment system may occur in January, April or July as necessary.*

## 40.2.4 – IPPS Transfers Between Hospitals

***(Rev.3373, Issued: 10-14-15, Effective 10-01-15, Implementation10-05-15)***

**A3-3610.5, HO-415.8**

A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See §20.2.3 for proper Pricer coding to ensure that these requirements are met.

Note: CMS established Common Working File Edits (CWF) edits in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

**A – Transfers Between IPPS Prospective Payment Acute Care Hospitals**

For discharges occurring on or after October 1, 1983, when a hospital inpatient is discharged to another acute care hospital, as described in 42 CFR 412.4(b), payment to the transferring hospital is based upon a graduated per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific MS-DRG into which the case falls; hospitals receive twice the per diem rate for the first day of the stay and the per diem rate for every following day up to the full MS-DRG amount). If the stay is less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital (see §40.1.D). If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate. Payment is made to the final discharging hospital at the full prospective payment rate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage index values and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-

DRG in the transferring hospital, payment to each is based upon the MS-DRG under which the patient was treated. For transfers on or after October 1, 1984, the transferring hospital may be paid an outlier payment. For further information on outlier payments for transfer cases, see section 20.1.2.4 of this manual.

An exception to the transfer policy applies to MS-DRG 789. The weighting factor for this MS-DRG assumes that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into this MS-DRG is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

Effective for discharges on or after October 1, 2003, patients who leave against medical advice (LAMA), but are admitted to another inpatient PPS hospital on the same day as they left, will be treated as transfers and the transfer payment policy will apply.

**B – Transfers from an IPPS Acute Care Hospital to Hospitals or Hospital Units Excluded from the IPPS**

When patients are transferred to hospitals or units excluded from IPPS, the full inpatient prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs or is made at the rate of its respective payment system (see exceptions in paragraph C of this section).

A transfer payment is made to the transferring hospital when patients are transferred to a hospital that would ordinarily be paid under prospective payment, but that is excluded because of participation in a state or area wide cost control program. Also, a transfer payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS and certain hospitals that are excluded from IPPS. These include:

- An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Status Code 02)

- A critical access hospital (Patient Status Code 66)

**C – Postacute Care Transfers**
**(Previously Special 10 DRG Rule)**

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying Postacute MS-DRGs referenced in paragraph (D) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under subpart B of 42 CRF 412). Facilities excluded from IPPS are

inpatient rehabilitation facilities and units (Patient Status Code *62*), long term care hospitals (Patient Status Code *63*), psychiatric hospitals and units (Patient Status Code 65), children's hospitals, and cancer hospitals (Patient Status Code 05).

- To a skilled nursing facility (Patient Status Code 03).

- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge (Patient Status Code 06).

Specific transfer cases under this paragraph qualify for payment under an alternative methodology. These include transfer cases in which the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in paragraph (D) of this section. For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

**D – Qualifying MS-DRGs**

Refer to Table 5 of the applicable Fiscal Year IPPS Federal Register for the list of qualifying Postacute MS-DRGs and Special Pay Postacute MS-DRGs.

## Addendum A - Provider Specific File

***(Rev.3373, Issued: 10-14-15, Effective 10-01-15, Implementation10-05-15)***

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 1 | 1-10 | X(10) | National Provider Identifier (NPI) | Alpha-numeric 10 character NPI number. |
| 2 | 11-16 | X(6) | Provider Oscar No. | Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of: |

| **Provider #** | **Provider Type** |
|---|---|
| 00-08 | Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12 |
| 12 | 18 |
| 13 | 23,37 |
| 20-22 | 02 |
| 30 | 04 |
| 33 | 05 |
| 40-44 | 03 |
| 50-64 | 32-34, 38 |
| 15-17 | 35 |
| 70-84, 90-99 | 36 |

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):

| **Special Unit** | **Prov. Type** |
|---|---|
| M - Psych unit in CAH | 49 |
| R - Rehab unit in CAH | 50 |
| S - Psych Unit | 49 |
| T - Rehab Unit | 50 |
| U - SB for short-term hosp. | 51 |
| W - SB for LTCH | 52 |
| Y - SB for Rehab | 53 |
| Z - SB for CAHs | 54 |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 3 | 17-24 | 9(8) | Effective Date | Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.<br>Year: Greater than 82, but not greater than current year.<br>Month: 01-12<br>Day: 01-31 |
| 4 | 25-32 | 9(8) | Fiscal Year Beginning Date | Must be numeric, CCYYMMDD.<br>Year: Greater than 81, but not greater than current year.<br>Month: 01-12<br>Day: 01-31<br>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.<br>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.<br>Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date.<br>If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number. |
| 7 | 49 | X(1) | Waiver Indicator | Enter a “Y” or “N.”<br>Y = waived (Provider is not under PPS).<br>N = not waived (Provider is under PPS). |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 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.<br>00 or blanks = Short Term Facility<br>02 Long Term<br>03 Psychiatric<br>04 Rehabilitation Facility<br>05 Pediatric<br>06 Hospital Distinct Parts<br>(Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54)<br>07 Rural Referral Center<br>08 Indian Health Service<br>13 Cancer Facility<br>14 Medicare Dependent Hospital<br>(during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid.<br>15 Medicare Dependent Hospital/Referral Center<br>(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.<br>16 Re-based Sole Community Hospital<br>17 Re-based Sole Community Hospital/ Referral Center<br>18 Medical Assistance Facility<br>21 Essential Access Community Hospital<br>22 Essential Access Community Hospital/Referral Center<br>23 Rural Primary Care Hospital<br>32 Nursing Home Case Mix Quality Demo Project – Phase II<br>33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| | | | | 34 Reserved<br>35 Hospice<br>36 Home Health Agency<br>37 Critical Access Hospital<br>38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998<br>40 Hospital Based ESRD Facility<br>41 Independent ESRD Facility<br>42 Federally Qualified Health Centers<br>43 Religious Non-Medical Health Care Institutions<br>44 Rural Health Clinics-Free Standing<br>45 Rural Health Clinics-Provider Based<br>46 Comprehensive Outpatient Rehab Facilities<br>47 Community Mental Health Centers<br>48 Outpatient Physical Therapy Services<br>49 Psychiatric Distinct Part<br>50 Rehabilitation Distinct Part<br>51 Short-Term Hospital – Swing Bed<br>52 Long-Term Care Hospital – Swing Bed<br>53 Rehabilitation Facility – Swing Bed<br>54 Critical Access Hospital – Swing Bed<br>**NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk). |
| 10 | 57 | 9(1) | Current Census Division | Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are:<br>1 New England<br>2 Middle Atlantic<br>3 South Atlantic<br>4 East North Central<br>5 East South Central<br>6 West North Central<br>7 West South Central |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| | | | | 8 Mountain<br>9 Pacific<br>**NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location. |
| 11 | 58 | X(1) | Change Code Wage Index Reclassification | Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. |
| 12 | 59-62 | X(4) | Actual Geographic Location - MSA | Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located. |
| 13 | 63-66 | X(4) | Wage Index Location - MSA | Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank. |
| 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. |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 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.<br>Leave blank for hospitals if there has not been a Lugar reclassification. |
| 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.<br>**IPPS**: Effective October 1, 2004, code a “Y” if the provider is considered “low volume.”<br>**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.<br>**IRF PPS:** Effective October 1, 2005, code a “Y” for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage |
| 18 | 75 | X(1) | Federal PPS Blend Indicator | **HH PPS:** Enter the code for the appropriate percentage payment to be made |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| | | | | on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000<br>0 = Pay standard percentages<br>1 = Pay zero percent<br>**IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002.<br>**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.<br>1 — Federal % 20 — Facility% 80<br>2 — 40 — 60<br>3 — 60 — 40<br>4 — 80 — 20<br>5 — 100 — 00<br>**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.<br>1 — Federal % 25 — Facility% 75<br>2 — 50 — 50<br>3 — 75 — 25<br>4 — 100 — 00 |
| 19 | 76-77 | 9(2) | State Code | Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code.<br>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 | 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- |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| | | | Rate | dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types. |
| 22 | 88-91 | 9V9(3) | Cost of Living Adjustment (COLA) | Enter the COLA. All hospitals except Alaska and Hawaii use 1.000. |
| 23 | 92-96 | 9V9(4) | Intern/Beds Ratio | Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period.<br>Enter zero for non-teaching hospitals.<br>**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.) |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 25 | 102-105 | 9V9(3) | Operating Cost to Charge Ratio | Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record.<br>For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register."<br>For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here.<br>See below for a discussion of the use of more recent data for determining CCRs. |
| 26 | 106-110 | 9V9(4) | Case Mix Index | The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix. |
| 27 | 111-114 | V9(4) | Supplemental Security Income Ratio | Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments. |
| 28 | 115-118 | V9(4) | Medicaid Ratio | Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments. |

| Data Element | File Position | Format | Title | Description |
|---|---|---|---|---|
| 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.<br>Blank = not applicable<br>Y = reclassified<br>1 = special wage index indicator<br>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.<br>Blank = hospital does not meet criteria<br>1 = hospital quality standards have been met |
| 35 | 140-144 | X(5) | Actual Geographic Location Core-Based Statistical Area (CBSA) | Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located. |
| 36 | 145-149 | X(5) | Wage Index Location CBSA | Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. |
| 37 | 150-154 | X(5) | 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 |

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

| Data Element | File Position | Format | Title | Description |
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| | | | | 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:<br>A = Hold Harmless – cost payment for old capital<br>B = Hold Harmless – 100% Federal rate<br>C = Fully prospective blended rate |
| 44 | 186-191 | 9(4)V9(2) | Hospital Specific Capital Rate | Must be present unless:<br>• A "Y" is entered in the Capital Indirect Medical Education Ratio field; or<br>• A“08” is entered in the Provider Type field; or<br>• A termination date is present in Termination Date field.<br>Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02. |
| 45 | 192-197 | 9(4)V9(2) | Old Capital Hold Harmless Rate | Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually. |
| 46 | 198-202 | 9V9(4) | New Capital-Hold Harmless Ratio | Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually. |
| 47 | 203-206 | 9V9(3) | Capital Cost-to-Charge Ratio | Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. |

| Data Element | File Position | Format | Title | Description |
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| | | | | See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems. |
| 48 | 207 | X(1) | New Hospital | Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation. |
| 49 | 208-212 | 9V9(4) | Capital Indirect Medical Education Ratio | This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital. |
| 50 | 213-218 | 9(4)V9(2) | Capital Exception Payment Rate | The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.) |
| 51 | 219-219 | X | VBP Participant | Enter “Y” if participating in Hospital Value Based Purchasing. Enter “N” if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N. |
| 52 | 220-231 | 9V9(11) | VBP Adjustment | Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank. |
| 53 | 232-232 | X | HRR Indicator | Enter “0” if not participating in Hospital Readmissions Reduction program. Enter “1” if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter “2” if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000. |
| 54 | 233-237 | 9V9(4) | HRR Adjustment | Enter HRR Adjustment Factor if “1” is entered in Data Element 53. Leave blank if ”0” or “2” is entered in Data Element 53. |
| 55 | 238-240 | V999 | Bundle Model 1 Discount | Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61). |
| 56 | 241-241 | X | HAC Reduction | Enter a ‘Y’ if the hospital is subject to a |

| Data Element | File Position | Format | Title | Description |
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| | | | Indicator | reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program. |
| *57* | *242-250* | *9(7)V99* | *Uncompensated Care Amount* | *Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital* |
| *58* | *251-251* | *X* | *Electronic Health Records (EHR) Program Reduction* | *Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.* |
| *59* | *252-260* | *X(9)* | *Filler* | |