CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 817

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JANUARY 20, 2006

Change Request 4279

NOTE: Transmittal 646 dated August 12, 2005 (CR 3940) is rescinded and replaced by this transmittal to include instructions for adding a Transitional Outpatient Payments (TOPs) Indicator field in the OPSF.

SUBJECT: Update to the Inpatient Provider Specific File (IPSF) and the Outpatient Provider Specific File (OPSF) to Retain Provider Information

I. SUMMARY OF CHANGES: CR 3940 was issued on August 12, 2005, and it included instructions for updating the IPSF and the OPSF. This CR rescinds and replaces CR 3940

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 1, 2006

IMPLEMENTATION DATE: April 3, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/Addendum A - Provider Specific File
R	4/50.1 - Outpatient Provider Specific File

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

50.1 - Outpatient Provider Specific File

(Rev. 817, Issued: 01-20-06, Effective: 04-01-06, Implementation: 04-03-06)

The outpatient provider (OPROV) specific file contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and format are shown below. FIs must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.
FIs must also furnish CMS a quarterly file in the same format.

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

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

49	X*(1)*	Waiver Indicator	*Enter a "Y" or "N."* *Y = waived (provider is not under OPPS)* *N = not waived (provider is under OPPS)*
50-54	9(5)	Intermediary Number	*Enter* the Intermediary #.
55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter *one of the following codes as appropriate*. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts *(Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, 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. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility *42 Federally Qualified Health Centers*

			43 Religious Non-Medical Health Care Institutions *44 Rural Health Clinics-Free Standing* *45 Rural Health Clinics-Provider Based* *46 Comprehensive Outpatient Rehab Facilities* *47 Community Mental Health Centers* *48 Outpatient Physical Therapy Services* *49 Psychiatric Distinct Part* *50 Rehabilitation Distinct Part* *51 Short-Term Hospital – Swing Bed* *52 Long-Term Care Hospital – Swing Bed* *53 Rehabilitation Facility – Swing Bed* *54 Critical Access Hospital – Swing Bed*
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. Does not apply to ESRD Facilities.
58	X*(1)*	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	*9(2)*	*State Code*	*Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. 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.*
73	*X(1)*	*TOPs Indicator*	*Enter the code to indicate whether TOPs applies or not.* *Y = qualifies for TOPs* *N = does not qualify for TOPs*
74-75	*X(2)*	*Filler*	*Blank.*
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.

80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the *Actual Geographic Location* CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	*The following codes indicate* the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

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

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 817	Date: January 20, 2006	Change Request 4279

NOTE: Transmittal 646 dated August 12, 2005 (CR 3940) is rescinded and replaced by this transmittal to include instructions for adding a Transitional Outpatient Payments (TOPs) Indicator field in the OPSF.

SUBJECT: Update to the Inpatient Provider Specific File (PSF) and the Outpatient PSF to Retain Provider Information

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) issued Change Request (CR) 3940, Transmittal 646, on August 12, 2005. CR 3940 modified both the Inpatient Provider Specific File (IPSF) and the Outpatient Provider Specific File (OPSF) to retain intelligence that would otherwise be lost in the transition from the OSCAR provider number to the National Provider Identifier (NPI). The following modifications were made to allow for more specificity and payment functionality:

1) Convert the 8-byte NPI field and the 2-byte NPI Filler field into a 10-byte NPI field; and
2) Add more provider type designations in the "Provider Type" field; and
3) Create the 2-byte, "State Code" field; and
4) Remove the 5-byte, "Bed Size" field in the OPSF only; and

Note: Bed size is used to calculate Transitional Outpatient Payments (TOPs). Because TOPs is discontinuing for rural Sole Community Hospitals (SCHs) and small rural hospitals effective January 1, 2006, CMS felt there was no longer a need for the "Bed Size" field in the OPSF.

Soon after the issuance of CR 3940, CMS became aware that there could be unintentional implications to removing the "Bed Size" field from the OPSF should the TOPs provision be reinstituted in the future. To prepare for such a situation, CMS decided that it could identify providers eligible for TOPs by using a 1-byte, "TOPS Indicator" field instead of a 5-byte, "Bed Size" field (to conserve limited field space in the OPSF). Thus, this CR is rescinding and replacing CR 3940 in order to combine the following changes with the changes already made per CR 3940:

- Add a 1-byte, "TOPS Indicator" field to the OPSF; and
- Include contractor instructions for maintaining the "TOPs Indicator" field; and
- Update the "Provider Type" fields in both the IPSF and the OPSF to identify specific swing bed provider types; and
- Include modifications to the IPSF record layout that were communicated in CR 4099 but were not included in CR 3940's original instructions.

Note: CR 4099, Transmittal 693, was issued on September 30, 2005 and was effective October 1, 2005. Because it was issued after the issuance of CR 3940, and because it was effective before the effective date

of CR 3940, neither of the CRs were consistent with each other. This CR merges all revisions made by CR 3940 and CR 4099.

B. Policy: Transitional Outpatient Payments (TOPs) to Rural Sole Community Hospitals (SCHs) and small rural hospitals are discontinuing effective January 1, 2006 (TOPs payments continue indefinitely for cancer and children's hospitals, regardless of bed size).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4279.1	Contractors and FISS shall update the following: • Inpatient Provider Specific File (IPSF) to include all fields as stated in the Medicare Claims Processing Manual, Chapter 3, Addendum A. • Outpatient Provider Specific File (OPSF) to include all fields as stated in the Medicare Claims Processing Manual, Chapter 4, Section 50.1.	X	X			X				
4279.1.1	Contractors and FISS shall convert the 8-byte NPI field and the 2-byte NPI Filler field into a 10-byte NPI field.	X	X			X				
4279.1.2	Contractors and FISS shall include the following new codes in the Provider Type field: 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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 "06" is effective until July 1, 2006. At that point, provider type "06" will 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.									
4279.1.3	FISS shall create a new 2-byte State Code field.					X				
4279.1.4	FIs shall enter the 2-byte state where the provider is located. **Note:** 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.	X	X							
4279.2	FISS shall create a new 1-byte "TOPs Indicator" field (OPSF only).					X				
4279.2.1	Contractors shall maintain the accuracy of the "TOPs Indicator" field.	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements
4279.1	FISS should modify any FISS screens to include the new 2-byte State Code field.
4279.2	FIs and FISS may want to consider auto-populating the State Code field using the first two digits of the OSCAR provider number. When doing this, however, FIs and FISS should ensure that the lowest state code is used for states that have more than one state code.
4279.3	FIs and FISS should modify their TOPS program to read the new "TOPs Indicator" in the OPSF.

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Joe Bryson (410-786-2986) or Stu Barranco (410-786-6152) **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Addendum A - Provider Specific File

(Rev.817, Issued: 01-20-06, Effective: 04-01-06, Implementation: 04-03-06)

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
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. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.

Data Element	File Position	Format	Title	Description
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 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)*

Data Element	File Position	Format	Title	Description
				07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990). 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility *42 Federally Qualified Health Centers* *43 Religious Non-Medical Health Care*

Data Element	File Position	Format	Title	Description
				Institutions *44 Rural Health Clinics-Free Standing* *45 Rural Health Clinics-Provider Based* *46 Comprehensive Outpatient Rehab Facilities* *47 Community Mental Health Centers* *48 Outpatient Physical Therapy Services* *49 Psychiatric Distinct Part* *50 Rehabilitation Distinct Part* *51 Short-Term Hospital – Swing Bed* *52 Long-Term Care Hospital – Swing Bed* *53 Rehabilitation Facility – Swing Bed* *54 Critical Access Hospital – Swing Bed* ***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).*
1*0*	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

Data Element	File Position	Format	Title	Description
				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.
1*1*	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.
1*2*	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.
1*3*	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.
1*4*	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.
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.

Data Element	File Position	Format	Title	Description
				Federal % Facility% 1 20 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. 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.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.

Data Element	File Position	Format	Title	Description
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 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.)

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 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.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). *Zero-fill* for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

Data Element	File Position	Format	Title	Description
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X*(1)*	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	*Zero-fill* for all hospitals after FY91. This Field is obsolete 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 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.

Data Element	File Position	Format	Title	Description
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.

Data Element	File Position	Format	Title	Description
41	173-178	9(4)V9*(2)*	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, *lung, pancreas, intestine* and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) *Zero-fill* if this does not apply.
42	179-184	9(4)V9*(2)*	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. *Zero-fill* if this does not apply.
43	185	X*(1)*	Capital PPS Payment Code	*Enter the code to indicate the type* of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9*(2)*	Hospital Specific Capital Rate	Must be present unless: • *A "Y" is entered in the Capital Indirect Medical Education Ratio field; or* • *A"08" is entered in the Provider Type field; or* • *A termination date is present in Termination Date field.*

Data Element	File Position	Format	Title	Description
				Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9*(2)*	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9*(3)*	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the 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

Data Element	File Position	Format	Title	Description
				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	219-240	X(22)	Filler	Blank.

I. Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and LTCH Prospective Payment Systems

Use of More Recent Data for Determining CCRs

A. Changing CCRs For Hospitals Subject to the IPPS

Under 42 CFR 412.84(i)(1), if more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate of increase among other hospitals), as explained below, CMS may direct the FI to change the hospital's operating and capital CCRs to reflect the high charge increases evidenced by the later data. A hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change.

FIs are to perform data analysis to identify those hospitals that appear to have disproportionately benefited from the time lag in updating the CCRs using the latest settled cost reports. These are hospitals:

1. With FY 2003 operating outlier payments of at least 10 percent of total operating diagnosis-related group (DRG) payments plus operating outlier payments;
2. Whose operating outlier payments relative to total operating DRG payments increased by at least 20 percent from either FY 2001 to FY 2002, or FY 2002 to FY 2003; and
3. Whose average charges per case increased by at least 15 percent both from FY 2000 to FY 2001, and from FY 2001 to FY 2002.

FIs are also to perform data analysis to identify hospitals that received operating outlier payments in excess of 100 percent of total operating DRG payments for FY 2003 (outlier payments divided by DRG payments).

Effective for discharges occurring on or after August 8, 2003, for hospitals that are identified through the above data analysis, FIs are to use an alternative CCR rather than one based on the latest settled cost report (such as a CCR based on data from the latest tentative settled cost report or more recent data) to identify and pay for outliers under the

IPPS. By July 25, 2003, for each of the hospitals identified, FIs should calculate a capital and operating CCR using the alternative data and submit this ratio to CMS (to the attention of Michael Treitel, e-mail at mtreitel@cms.hhs.gov). CMS will notify FIs whether to use these ratios or an alternative ratio. For all IPPS claims processed on or after August 8, 2003, until more accurate data becomes available, FIs are to use this approved alternative ratio.

B. Use of Alternative Data in Determining CCRs For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

Under 42 CFR 412.84(i)(1) of the IPPS and 42 CFR 412.525(a)(4)(ii), 42 CFR 412.529(c)(5)(ii) of the LTCH PPS, CMS may direct FIs to use an alternative CCR to the CCRs from the later of the latest settled cost report or latest tentative settled cost report), if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the FI should contact CMS to seek approval to use a CCR based on alternative data.

Also, a hospital may request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the hospital.

C. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For discharges beginning on or after October 1, 2003, FIs use CCRs from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs. By October 1, 2003, for all hospitals that are paid under the IPPS or LTCH PPS, FIs must have updated CCRs on the Provider Specific File (PSF) to reflect CCRs from the most recent tentative settlements or final settled cost reports, (whichever is the later period). These updated CCRs are used to process claims with discharge dates on or after October 1, 2003. The CCR on the PSF must be updated when that cost report is settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever is the latest cost reporting period.

In order to arrive at CCRs to be used in the PSF based on tentative settlement data, the FI should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCRs to determine if they had an impact on the CCRs. If these tentative settlement adjustments have no impact on the CCRs, or if no adjustments were made, the tentative settled CCRs will equal the CCRs from the hospital's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCRs, the FI should compute new CCRs based on the tentative settlement. (Note: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20 percent or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of CCRs for all hospitals for discharges on or after October 1, 2003, FIs should continue to update a hospital's operating and capital CCRs each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. Revised CCRs will be applied prospectively to all IPPS and LTCH PPS claims processed after the update.

II. Statewide Average for Hospitals Subject to the IPPS and for Hospitals Subject to the LTCH PPS

Prior to August 8, 2003, hospitals were assigned a statewide average CCR if their actual operating or capital CCR fell outside 3 standard deviations from the respective national geometric mean CCR.

Effective August 8, 2003, a hospital is longer be assigned the statewide average CCR when the hospital has a CCR that falls below 3 standard deviations from the national mean. Hospitals receive their actual CCRs, no matter how low their ratios fall.

The statewide average CCRs may still apply in those instances in which a hospital's operating or capital CCRs exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report may still receive the statewide average CCRs. CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the statewide CCRs applicable to IPPS hospitals and LTCHs in each year's annual notice of prospective payment rates published in the "Federal Register."

III. Reconciling Outlier Payments For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For the hospitals under the IPPS for which the FI applied alternative CCRs for discharges occurring on or after August 8, 2003 (that were identified through the above 3-step data analysis), and, for discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, FIs reconcile outlier payments at the time of cost report final settlement if:

1. Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
2. Total outlier payments in that cost reporting period exceed $500,000.

Consistent with the June 9, 2003 Federal Register (68 FR 34504) in which CMS indicated that it intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow FIs to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs. Similarly, for hospitals subject to the LTCH PPS, for discharges occurring in cost reporting periods beginning on or after October 1, 2003, reconciliation should be made if:

1. Actual operating CCRs are found to be plus or minus 10 percentage points from the CCRs used during that cost reporting period to make outlier payments, and
2. High cost outlier payments made under 412.525 and short stay outlier payments made under 42 CFR 412.529 combined exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which high cost outlier and/or short stay outlier payments were made in a cost reporting period.

If the above criteria for IPPS hospitals and LTCHs do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for those hospitals are significantly inaccurate, FIs have the administrative discretion to reconcile cost reports of those additional IPPS hospitals and LTCHs. However, FIs must seek approval from their CMS Regional Office in the event they intend to reconcile outlier payments for an IPPS hospital or a LTCH that does not meet the above-specified criteria.

IV. Notification to Hospitals under the IPPS and the LTCH PPS

The FIs are to notify a hospital whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.