Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 1702, 03-13-09)

10 - General Inpatient Requirements

(Rev. 1, 10-01-03)
HO-400, HO-400.G, HO-403, HO-412

The hospital may bill only for services provided. If the provider billing system initiates billing based on services ordered, the provider must confirm that the service has been provided before billing either the carrier or intermediary (FI).

The provider agreement to participate in the program requires the provider to submit all information necessary to support claims for services. Failure to submit such information in an individual case will result in denial of the entire claim, the charging of utilization in inpatient cases to the beneficiary record, and a prohibition against the provider billing or collecting from the beneficiary or other person for any services on the claim. A provider with a common practice of failing to submit necessary information in connection with its claims subjects itself to possible termination of its participation in the program. (See chapter 1.)

State agencies will find that a significant deficiency exists in complying with the conditions of participation if the hospital repeatedly fails to transfer appropriate medical information when patients are transferred to other health facilities. Appropriate medical information includes the discharge summary, the physician's medical orders, and a summary of departmental medical records. The hospital must obtain the patient's consent for the release of medical information as soon as the decision to transfer is made, unless a blanket authorization was obtained at admission.

10.1 - Forms

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Form CMS-1450, Inpatient and/or Outpatient Billing, or the electronic equivalent, is used for all provider billing, except for the professional component of physicians services. (See Chapter 25 for instructions for hospital services and Chapter 26 for instructions for physician services.)

Providers are responsible for purchasing their own forms. They can be bought as a regular stock item from many printers as a snap-out set or as a continuous pin-feed form (either glued on the side or not) and are available as carbonless or with carbon paper. Medicare accepts them all. The standard form set contains four copies, one page of which is designed to bill the patient.

Special orders can be made for fewer copies, e.g., one-part for a Medicare hospice election, three-part excluding patient copy.

A. Form CMS-1490S Patient's Request for Medicare Payment

Only beneficiaries (or their representatives) who complete and file their own claims use this. Providers have no need for this form.

B. Form CMS-1500 Health Insurance Claim Form
HH-424

This is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned. Institutional providers may use the Form CMS-1500 to bill the Part B carrier for the professional component of physicians' services where applicable.

Form CMS-1450, is processed by the provider's FI.

10.2 - Focused Medical Review (FMR)

(Rev. 1, 10-01-03)
HO-419, HH-450, HH-452, HH-462.1

This section has been moved to the Program Integrity Manual, which can be found at the following Internet address http://www.cms.hhs.gov/manuals/cmsindex.asp.

10.3 - Spell of Illness

(Rev. 1, 10-01-03)
A3-3622

The FI makes spell of illness determinations in accordance with the Medicare Benefit Policy Manual, Chapter 3, and these special instructions.

A. Beginning a Spell of Illness in Nonparticipating Provider

The noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or an SNF that meets all requirements in the definition of such an institution even though it may not be participating.

It is most unlikely that a nonparticipating hospital that is not accredited by JCAHO or a nonparticipating SNF satisfies the conditions of participation, particularly with regard to utilization review. Therefore, for spell of illness purposes, the FI assumes that nonparticipating providers are not qualified providers in the absence of evidence to the contrary. Situations that might constitute such contrary evidence include cases where the provider recently dropped out of the program or, after a survey by the State agency, decided not to participate even though the conditions of participation were met. Hospitals accredited by JCAHO are deemed to meet all requirements except utilization review. For such a hospital, the FI determines through the RO whether the hospital has a utilization review plan in effect.

B. Continuing a Spell of Illness

1. Hospital Services

For purposes of continuing a spell of illness in a hospital, the hospital in which the stay occurs need not meet all requirements that are necessary for starting a spell of illness. If there has been a stay in a hospital that might continue the spell of illness and the FI cannot ascertain its status, the FI contacts the RO, which maintains a list of all medical facilities and their status.

2. SNF Services

For purposes of continuing a spell of illness in a SNF the spell of illness ends when the beneficiary no longer needs or receives a Medicare covered level of care.

The FI uses the following seven presumptions to determine whether the skilled level of care standards were met during a prior SNF stay. If the information upon which to base a presumption is not readily available, the FI may, at its discretion, review the beneficiary's medical records to determine whether the beneficiary was an inpatient of an SNF for purposes of ending a spell of illness.

These special rules for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is seeking to continue a benefit period, but also where it results in the beneficiary starting a new benefit period. If the applicable skilled level of care standards were met during a prior SNF stay, the spell of illness is continued with current utilization available to the beneficiary. If the applicable skilled level of care standards were not met during a prior SNF stay, the spell of illness is not continued. A new spell of illness restores full utilization and imposes a cash deductible.

Presumptions:

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation of liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a noncertified bed. See Chapter 30.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules in Chapter 30. (This presumption does not apply to placement in a noncertified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if

paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in an SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Rebuttal of Presumptions

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation. Although Presumptions 1 through 4 are not in themselves rebuttable, a beneficiary may seek to reverse a benefit period determination that was dictated by one of these presumptions by timely appealing the prior Medicare or Medicaid claim determination which triggered the presumption.

Presumptions 5 through 7 can be rebutted by beneficiary showings that the level of care needed or received is other than that which the presumption dictates. Rebuttal showings are permitted at both FI determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial. Decisions under presumptions 5 through 7 require the FI to send a notice to advise the beneficiary of the basis for the determination and the right to present evidence to rebut the determination on reconsideration.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. For example, prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for an SNF stay because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when Medicare SNF payment is denied, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations to extend a benefit period if this would be to the beneficiary's advantage.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption.

Medicare no payment bills submitted by an SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no payment bills which lead to Medicaid program payment determinations. If an SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, request compliance. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Some of the presumptions require knowledge of Medicaid's claims processing involvement with the prior claim. The FI uses current bill data, accompanying documentation, bill history files, and telephone contacts with the prior stay facility and/or the Medicaid agency to develop the Medicaid aspects. It does not continue Medicaid development beyond a telephone contact. It concludes its consideration of the presumption at this point based upon the Medicaid information available.

10.4 - Payment of Nonphysician Services for Inpatients

(Rev. 1, 10-01-03)
HO-407

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS.

A. Other Medical Items, Supplies, and Services

The following medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services);

- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;

- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic;

- Total parenteral nutrition (TPN) services; and

- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient.

The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540.

EXCEPTIONS:

- **Pneumococcal Vaccine -** is payable under Part B only and is billed by the hospital on the Form CMS-1450.

- **Ambulance Service -** For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted it does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the carrier by the ambulance operator or beneficiary, as appropriate, if an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance trip is considered part of the DRG, and not separately billable, if the resident hospital is under PPS.

- **Part B Inpatient Services -** Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services. See Chapter 4 for a description of Part B inpatient services.

- **Anesthetist Services "Incident to" Physician Services -** If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these

services and that practice was in effect as of the last day of the hospital's most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist's service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ certified registered nurse anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital's cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

B. Exceptions/Waivers

These provisions were waived before cost reporting periods beginning on or after October 1, 1986, under certain circumstances. The basic criteria for waiver was that services furnished by outside suppliers are so extensive that a sudden change in billing practices would threaten the stability of patient care. Specific criteria for waiver and processing procedures are in §2804 of the Provider Reimbursement Manual (CMS Pub. 15-1).

10.5 – Hospital Inpatient Bundling

(Rev. 668, Issued: 09-02-05; Effective: Ambulance claims received on or after January 3, 2006, and 4 years after initial determination for adjustments; Implementation: 01-03-06)

Hospital bundling rules exclude payment to independent suppliers of ambulance services for beneficiaries in a hospital inpatient stay. The Common Working File (CWF) performs reject edits to incoming claims from independent suppliers of ambulance services. The CWF searches paid claim history and compares the line item service date on an ambulance claim to the admission and discharge dates on a hospital inpatient stay. The CWF rejects the line item when the ambulance line item service date falls within the admission and discharge dates on a hospital inpatient claim. Based on CWF rejects, the carrier must deny line items for ambulance services billed by independent suppliers that should be bundled to the hospital.

Upon receipt of a hospital inpatient claim, CWF searches paid claim history and compares the period between the hospital inpatient admission and discharge dates to the line item service date on an ambulance claim billed by an independent supplier. The CWF shall generate an unsolicited response when the line item service date falls within the admission and discharge dates of the hospital inpatient claim.

Upon receipt of the unsolicited response, the carrier shall adjust the ambulance claim and recoup the payment.

Ambulance services with a date of service that is the same as the admission or discharge date on an inpatient claim are separately payable and not subject to the bundling rules.

The CWF performs an additional edit before determining if the ambulance line item should be rejected when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF) or inpatient rehabilitation facility (IRF) and is transported via ambulance to an acute care hospital to receive specialized services. The CWF edits the claim for the presence of occurrence span code 74 (non-covered level of care) and the associated occurrence span code from and through dates. The CWF bypasses the reject edit when the ambulance line item service date falls within the occurrence span code 74 from and through dates plus one day. In this case, the ambulance line item is separately payable. The CWF rejects the ambulance line item when the service date falls outside the occurrence span code 74 from and through dates plus one day.

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A. General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County

Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

The OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first 2 years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B. Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18.

Hospitals located outside the 50 States.

- Hospitals participating in a CMS-approved demonstration project or State payment control system.

- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

C. Situations Requiring Special Handling

1. Sole community hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2. Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as comprehensive cancer centers or clinical research centers;

- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3. Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4. Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5. Kidney, heart, and liver acquisition costs incurred by approved transplant centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6. Religious nonmedical health care institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by Pricer.

7. Transferring hospitals with discharges assigned to MS-DRG 789 (neonates, died or transferred to another acute care facility) or MS-DRG 927-935 (burns - transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8. Nonparticipating hospitals furnishing emergency services are not included in PPS.

9. Veterans Administration (VA) hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10. A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983, may qualify for

special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11. The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.

- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12. Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13. Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and

- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D. MS-DRG Classification

The MS-DRGs (Medicare Severity DRGs) are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 745 diagnosis related groups (DRGs).

The following MS-DRGs receive special attention:

- **MS-DRGs No. 981-983** - Represent discharges with valid data, but the surgical procedure is unrelated to the principal diagnosis. MS-DRGs 981 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ MCC), 982 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ CC), and 983 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/o CC/MCC) each have relative weights assigned to them and will be paid. The hospital must review the record on each of these MS-DRGs in the remittance record and determine that where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The FI may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment.

- **MS-DRG No. 998** - Represents a discharge reporting a principle diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for MS-DRG assignment purposes. FIs will return the claims. The hospital must enter the corrected principal diagnosis for proper MS-DRG assignment and resubmit the claim.

- **MS-DRG No. 999** - Represents a discharge with invalid data, making it ungroupable. FIs return the claims for correction of data elements affecting proper MS-DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E. Difference in Age/Admission Versus Discharge HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

20.1 – Hospital Operating Payments Under PPS
(Rev. 70, 01-23-04)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Under the PPS, Medicare payment for hospital inpatient operating costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the PPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the PPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the PPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and small rural

Medicare-dependent hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the PPS rate and their hospital-specific rates if the hospital-specific rate is higher than the PPS rate).

The existing regulations governing payments to hospitals under the PPS are located in 42 CFR Part 412, Subparts A through M.

20.1.1 – Hospital Wage Index
(Rev. 70, 01-23-04)

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. CMS defines hospital geographic areas (labor market areas) based on the definitions of urban (e.g., Metropolitan Statistical Areas (MSAs)) and rural areas issued by the Office of Management and Budget.

The Act further requires the wage index to be updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. These data are collected on Worksheet S-3, Parts II and III of the Medicare Cost Report (Form CMS-2552). To ensure the accuracy of the wage index, fiscal intermediaries are required to perform annual desk reviews of hospitals' wage data. CMS also publishes the wage data, and allows hospitals an opportunity to review and request corrections to the data, before the wage index is finalized.

In computing the wage index, CMS derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals surveyed in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. If a labor market area's average hourly wage is greater than the national average, the area's wage index value will be greater than 1.0000. If an area's average hourly wage is less than the national average, the area's wage index value will be less than 1.0000. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.

Section 4410 of Public Law 105-33 provides that, for discharges on or after October 1, 1997, the area wage index value applicable to any hospital that is located in an urban area may not be less than the area wage index value applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply.

20.1.2 - Outliers

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

The actual determination of whether a case qualifies for outlier payments is made by the fiscal intermediary (FI) or A/B Medicare Administrative Contractor (MAC) using Pricer, which takes into account both operating and capital costs and diagnostic related group (DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs). Any outlier payment due is added to the DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp.

The A/B MACs or the FI may choose to review outliers if data analysis deems it a priority.

The IPPS outliers are not applicable to non-PPS hospitals. The Pricer program makes all outlier determinations except for the medical review determination. Outlier payments apply only to the Federal portion of a capital PPS payment.

20.1.2.1 - Cost to Charge Ratios

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

A. Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs is determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its FI, which includes Medicare allowable costs and charges. The FIs complete a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The FI shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period). Effective November 7, 2005, the following methodology shall be used to calculate a hospital's operating and capital CCRs.

Inpatient PPS Operating CCR

1) Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).

2) Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.

Inpatient Capital CCR

1) Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 10, sum of lines 25 through 30, plus column 12, sum of lines 25 through 30 plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column 6, line 101 plus column 8 line 101.

2) Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.

3) Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.

B. Use of Alternative Data in Determining CCRs For Hospitals and Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

For discharges before August 8, 2003, FIs used the latest final settled cost report to determine a hospital's CCRs. For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 FIs are to use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR (to download PM A-03-058, visit our Web site at http://www.cms.hhs.gov/Transmittals/Downloads/A03058.pdf). For all other hospitals, effective October 1, 2003, FIs are to use CCRs from the latest final 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.

The FIs shall continue to update a hospital's operating and capital CCRs each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Effective August 8, 2003, the central office may direct FIs to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, 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 shall notify the CMS regional office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The regional office, in conjunction with the central office, must approve the FI's request before the FI may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. FIs shall send notification to the central office via the following address and email address:

CMS
C/O Division of Acute Care- IPPS Outlier Team
7500 Security Blvd
Mail Stop C4-08-06
Baltimore, MD 21244
outliersIPPS@cms.hhs.gov

C. Request for use of a Different CCR

Effective August 8, 2003, CMS (or the FI) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a hospital will have the opportunity to 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. After the FI has evaluated the evidence presented by the hospital, the FI notifies the CMS regional office and CMS Central Office of any such request. The CMS regional office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital or FI for use of a different CCR. FIs shall send requests to the CMS Central Office using the address and email address provided above.

D. Notification to Hospitals Under the IPPS of a Change in the CCR

The FI shall notify a hospital whenever it makes 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 can be included in the notice that is issued to each provider after a tentative or final

settlement is completed. FIs can also issue separate notification to a hospital about a change to their CCR(s).

E. Hospital Mergers, Conversions, and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, FIs shall continue to use the operating and capital CCRs from the hospital with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, FIs may use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). For non-IPPS hospitals (e.g., long term care, psychiatric, or rehabilitation hospitals) that convert to IPPS status, or IPPS hospitals that maintain their IPPS status but receive a new IPPS provider number the Statewide average CCR may be applied to that hospital. However, as noted in part C above, the FI or the hospital may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report before it converted to IPPS status, or received a new provider number. The FI must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS central and regional offices.

In instances where errors related to CCRs and/or outlier payments are discovered, FIs shall contact the CMS Central Office to seek further guidance. FIs may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, FIs should contact the CMS regional and Central Office for further instructions. FIs may contact the CMS Central Office via the address and email address listed in part B of this section.

F. Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, FIs shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary.

20.1.2.2 - Statewide Average Cost-to-Charge Ratios

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

For discharges prior to August 8, 2003, Statewide average CCRs are used in those instances in which a hospital's operating or capital CCRs fall above or below reasonable

parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the FI may use a Statewide average CCR if it is unable to determine an accurate operating or capital CCR for a hospital in one of the following circumstances:

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 489.18.)

2. Hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b) of the CFR.

3. Other hospitals for whom accurate data with which to calculate either an operating or capital CCR (or both) are not available.

However, the policies of §20.1.2.1 part C and part E can be applied as an alternative to the Statewide average.

For those hospitals assigned the Statewide average operating and/or capital CCRs, these CCRs must be updated every October 1 based on the latest Statewide average CCRs published in each year's annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of §20.1.2.1 part C of this manual.

A hospital is not assigned the Statewide average CCR if its CCR falls below 3 standard deviations from the national mean CCR. In such a case, the hospital's actual operating or capital CCR is used.

20.1.2.3 - Threshold and Marginal Cost

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The FI, using Pricer, determines an appropriate additional payment for inpatient services where hospital charges for covered services furnished to the beneficiary, adjusted for cost, are extraordinarily high. CMS annually determines, and includes in the annual IPPS Final Rule and in Pricer, the threshold beyond which a cost outlier is paid. The additional payment amount is the difference between the estimated cost for the discharge (determined by multiplying the hospital specific CCR by the hospital's charges for the discharge) and the threshold criteria established for the applicable DRG multiplied by a marginal cost factor of 80 percent. (The marginal cost factor for burn cases is 90 percent, as described in section 20.1.2.8.) CMS includes the marginal cost factor in Pricer. For more explanation on the calculation of outliers visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp

20.1.2.4 - Transfers

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

A. Transfers Between IPPS Hospitals

For transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day.

The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. For further information on transfers between IPPS hospitals, see section 40.2.4 part A of this manual.

B. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that do not Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the postacute care transfer policy, the transferring hospital is paid the full IPPS rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold and payment are calculated the same as any other discharge without a transfer.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that do not fall within a DRG that is subject to the postacute care transfer policy, see section 40.2.4 part B of this manual.

C. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is subject to the postacute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day. If a discharge is assigned to a special pay DRG subject to the post acute care transfer policy the outlier threshold is equal to the fixed-loss cost outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by 0.5 plus the product of the length of stay plus one day multiplied by 0.5.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that fall within a DRG subject to the postacute care transfer policy, see section 40.2.4 part C and D.

20.1.2.5 - Reconciliation
(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

A. General

Under 42 CFR § 412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that FIs identified using the criteria in section I.A. of PM A-03-058 (under which FIs identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Subject to the approval of the CMS central office, a hospital's outlier claims will be reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2. Total outlier payments in that cost reporting period exceed $500,000.

To determine if a hospital meets the criteria above, the FI shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, FIs shall follow the instructions below in §20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The first criterion requires a 10 percentage point fluctuation in the operating CCR only (and not the capital CCR). However, if a hospital meets both criteria, claims will be reconciled using the operating and capital CCRs from the final settled cost report.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), FIs shall notify the CMS regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §20.1.2.1 (b).

Any cost report that has been final settled prior to the initial issuance of this manual revision (CR 3966, Transmittal 707 October 12, 2005) that meets the qualifications for

reconciliation shall be reopened. FIs shall notify the CMS Central Office and regional office that the outlier payments need to be reconciled, using the procedures in §20.1.2.7. After CMS's approval of the reconciliation, the FI shall issue a reopening notice to the provider.

B. Reconciling Outlier Payments for those Hospitals Identified in PM A-03-058

As stated above, for a hospital that met the criteria in section I.A. of PM A-03-058, reconciliation begins for discharges occurring on or after August 8, 2003. To establish whether a hospital's outlier payments are subject to reprocessing, FIs determine if the CCR and total outlier payments from the entire cost reporting period meet the two criteria in part A of this section. However, if both criteria for reconciliation are met, only the discharges that occurred between August 8, 2003 and the end of the cost reporting period will be reconciled. These hospitals will be subject to reconciliation in subsequent cost reporting periods if they meet the two criteria outlined in part A of this section. See example A below.

The FIs shall notify the regional office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent to the address and email address provided in §20.1.2.1. Further instructions for FIs on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

EXAMPLE A:

Cost Reporting Period: 09/01/2002-08/31/2003

Operating CCR used to pay original claims submitted during cost reporting period: 0.40
(In this example, this CCR is from the tentatively or final settled 2002 cost report)
Final settled operating CCR from 09/01/2002-08/31/2003 cost report: 0.50

Total outlier payout in 09/01/2002-08/31/2003 cost reporting period: $600,000
Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the provider's claims for discharges from August 8, 2003 through August 31, 2003 shall be reconciled using the correct CCR of 0.50. The same criteria shall be applied to the cost report beginning on 09/01/2003 to determine whether reconciliation of outlier payments for that cost reporting period is necessary. For details on how to apply multiple CCRs in a cost reporting period, see example C below.

C. Reconciling Outlier Payments for those Hospitals Not Identified in PM A-03-058

Beginning with the first cost reporting period starting on or after October 1, 2003, all hospitals are subject to the reconciliation policies set forth in this section. If a hospital meets the criteria in part A of this section, the FIs shall notify the regional office and central office at the address and email address provided in §20.1.2.1. Further instructions

for FIs on reconciliation and the time value of money are provided below in §§20.1.2.6, 20.1.2.7 and 20.1.2.8. The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE B:

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the FI notifies the regional office and central office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, FIs should calculate a weighted average of the CCRs in that cost reporting period. (See Example C below for instructions on how to weight the CCRs). The FI shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the <u>entire</u> cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE C:

Cost Reporting Period: 01/01/2004-12/31/2004
Operating CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2004-03/31/2004 (This CCR could be from the tentatively settled 2001 cost report)

- 0.50 from 04/01/2004-12/31/2004 (This CCR could be from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.35
Total Outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000
Weighted Average CCR: 0.474

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375=

			(0.50 * 0.751)
TOTAL	**366**		**(a)+(b) =0.4742**

The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.474 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.

Even if a hospital does not meet the criteria for reconciliation in part A of this section, subject to approval of the regional and central office, the FI has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The FI sends notification to the central office via the address and email address provided in §20.1.2.1 (b). Upon approval of the regional and central office that a hospital's outlier claims need to be reconciled, FIs should follow the instructions in §20.1.2.7.

20.1.2.6 - Time Value of Money

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under section 20.1.2.5, outlier payment may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled to the date on which the CMS Central Office receives notification from the FI that reconciliation should be performed.

If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula will be used to calculate the rate of the time value of money.

(Rate from Web site as of the midpoint of the cost report being settled / 365 or 366) * # of days from that midpoint until date of reconciliation.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the FI, or the date an email was received from the FI by the CMS Central Office, whichever is first.

20.1.2.7 - Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments

(Rev. 1072, Issued: 10-06-06; Effective/Implementation Date: 11-06-06)

The following is a step-by-step explanation of how FIs are to notify CMS and hospitals that reconciliation should be performed and to record reconciled outlier claims for hospitals that meet the criteria for reconciliation:

1) The FI sends notification to the CMS central office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation.

2) If the FI receives approval from the CMS central office that reconciliation is appropriate, the FI follows steps 3-8 below.

3) The FI shall notify the hospital and copy the CMS regional office and central office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital's outlier claims are to be reconciled.

4) The FI shall submit to the central office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report. The FI submits this data (preferably in electronic format) to the central office via the addresses provided above. Data fields that shall be submitted include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.

5) Central office will use data from National Claims History (NCH) to reprocess claims in a Pricer utility program to determine the correct outlier payment amounts.

6) CMS will calculate the time value of money attributable to the adjustment. CMS will provide the FI with a log of individual claims on which the total adjustment was determined.

7) The FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.

8) The FI shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

The central office will work as quickly as possible to reconcile these claims in order to allow FIs to finalize the cost report and issue an NPR within the normal CMS timeframes. If an FI has any questions regarding this process it should contact the central and regional office, using the address and email address provided in §20.1.2.1 (B).

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

EXAMPLE D:

Cost Reporting Period: 01/01/2004-12/31/2004
Midpoint of Cost Reporting Period: 07/01/2004
Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

Operating CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The FI notifies the regional and central office.

The central office reprocesses the claims. The reprocessing indicates the revised outlier payments are $700,000.

Using the values above, determine the rate that will be used for the time value of money:
(4.625 / 365) * 549 = 6.9565%
Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.

20.1.2.8 - Special Outlier Payments for Burn Cases

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of

prospective payment rates is computed using the same methodology (as stated above in section 20.1.2.3) except that the payment is made using a marginal cost factor of 90 percent instead of 80 percent.

20.1.2.9 - Medical Review and Adjustments

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Effective April 1, 2008, QIOs are no longer performing the majority of medical review for payment of acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims. These reviews are the responsibility of the A/B MACs or the FIs. An exception occurs when a provider requests a higher-weighted DRG review from the QIO. The QIO will continue to perform those reviews.

The A/B MAC or the FI may review a sample of cost outlier cases after payment. The charges for any services identified as non-covered through this review are denied and any outlier payment made for these services is recovered, as appropriate, after a determination as to the provider's liability has been made.

If the A/B MAC or the FI finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital may be subject to medical review, and this review may be conducted prior to payment until the A/B MAC or the FI determines that appropriate corrective actions have been taken.

When the A/B MAC or the FI reviews cost outlier cases, they shall do so using the medical records and itemized charges, to verify the following:

1. The admission was medically necessary and appropriate;

2. Services were medically necessary and delivered in the most appropriate setting;

3. Services were ordered by the physician, actually furnished, and not duplicatively billed; and

4. The diagnostic and procedural coding are correct.

Where the A/B MAC's or the FI's decision changes previously processed bills, an adjustment bill is prepared to correct the bill.

When the hospital provides the A/B MACs or the FIs with medical records for cost outlier review, the hospital must indicate the precise revenue code for each charge billed. In case adjustments are needed, revenue codes are necessary to ensure proper accounting for cost report purposes. It is not acceptable for the hospital to merely provide listings of revenue codes expecting the A/B MACs or the FIs to assign the charges to the appropriate code. If the correct revenue codes are not provided, the A/B MACs or the FIs will deny the bill.

20.1.2.10 - Return Codes for Pricer

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The following return codes are calculated by PRICER and passed back to the calling program. Depending on the type of payment and case, return codes 30, 44, 33, 40 and 42 indicate that an outlier would be paid if the cost-to-charge ratio would rise by 20 percentage points. If a provider(s) (CCR rises by 10 percentage points and) meets the criteria of reconciliation, the CMS Central Office uses return codes 30, 44, 33, 40 and 42 to determine a smaller pool of claims for reprocessing claims due to outlier reconciliation.

Acute Care

Return Code 00: Paid normal DRG payment.

Return Code 02: Paid normal DRG payment plus a cost outlier.

Return Code 14: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay.

Return Code 16: Paid normal DRG payment plus a cost outlier with per diem days equal to or greater than geometric mean length of stay.

Return Code 30: Paid normal DRG payment and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Return Code 44: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Transfer Cases

Return Code 03: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated.

Return Code 05: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates case qualified for a cost outlier payment.

Return Code 06: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered

days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates provider refused cost outlier payment.

Return Code 33: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Post Acute Transfer Cases

Return Code 10: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay the standard payment is also calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 12: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 40: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Return Code 42: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the

geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

20.2 - Computer Programs Used to Support Prospective Payment System

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Medicare Code Editor

The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include correct ICD-9-CM coding, coverage, and clinical edits.

Built into the MCE, which is the first portion of the Grouper program, are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review may be conducted by the A/B MACs or the FIs, using medical records and the approved claim.

Grouper Program

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

Pricer Program

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary who's benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below. Hospitals and hospital claims in multiple geographic areas may obtain a Pricer from

National Technical Institute
U.S. Department of Commerce
NTIS
Springfield, VA 22161.

Hospitals may also download a PC Pricer that will process one record at the time from the CMS Web site at: http://www.cms.hhs.gov/providers/pricer/default.asp.

20.2.1 - Medicare Code Editor (MCE)

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A. General

The MCE edits claims to detect incorrect billing data. In determining the appropriate 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 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 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 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 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 (9 maximum – principal diagnosis and up to 8 additional diagnoses);
- Procedures (6 maximum); and
- Discharge date.

The MCE provides the FI an analysis of "errors" on the bill as described in subsection D. The FI 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 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 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. Invalid Fourth or Fifth Digit

The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The FI returns claims edited for this reason to the hospital. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

3. 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.

4. 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 will delete the duplicate secondary diagnosis and process the bill.

5. 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 diagnoses described in the Medicare Code Editor, posted on the CMS Webpage at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10 are acceptable only for the age categories shown. If the FI edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI 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.

6. 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 Medicare Code Editor 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.

7. 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 Medicare Code Editor 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.

8. 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.

9. 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 Medicare Code Editor 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.

10. 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 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.

11. 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.

12. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment. The FI will return the bill requesting either:

- A no pay bill, or
- A correction in the procedure code.
- A bill indicating the covered and noncovered procedures.

If the hospital indicates that there are covered and noncovered procedures, the FI refers the bill to the QIO for prepayment review. Upon receipt of the QIOs response, it either deletes the noncovered procedures and charges or requires the hospital to delete them. It does not process the noncovered procedures through Grouper or the noncovered charges through Pricer.

13. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The DRG Grouper logic assign a patient to different 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 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 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 assigns the appropriate closed biopsy code after reviewing the medical information.

14. Medicare as Secondary Payer - MSP Alert

The MCE identifies situations that may involve automobile medical, no-fault or liability insurance. The hospital must develop other insurance coverage as provided in the Medicare Secondary Payer Manuals, before billing Medicare.

15. 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 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 may develop claims prior to payment on a provider-specific basis.

16. Invalid Age

If the hospital reports an age over l24, the FI 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.

17. Invalid Sex

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

18. Invalid Discharge Status

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

19. 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.

20 – 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 will handle these procedures as they had previously.

20.2.1.1 - Paying Claims Outside of the MCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

All institutional inpatient claims are routed through the MCE before they are processed to payment. There may be special circumstances, however, when it is necessary to pay claims bypassing MCE edits. The CMS will notify the contractor of these instances. They include:

- New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes timely; and

- Errors are discovered that cannot be corrected timely.

A/B MACs and FIs are responsible for reporting problems timely.

20.2.1.1.1 - Requesting to Pay Claims Without MCE Approval

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

The contractor may also request approval from the RO in specific situations to pay claims without first sending them through the MCE. Examples of such situations are:

- A systems error cannot be corrected timely, and the provider's cash flow will be substantially impacted; and/or

- Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal process.

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

Before an inpatient claim may be paid without first going through the MCE, the contractor shall obtain approval from CMS Central Office or the RO.

Note: In certain situations, contractors bypass the MCE through an established, CMS-instructed claim processing procedure (e.g., to verify a facility is certified to perform a specified service after a MCE limited coverage edit is applied). Such scenarios do not

require approval from the RO as the approval for such a bypass was inherently implied when the established procedure was first implemented.

In all instances involving payment outside the normal inpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the MCE using the appropriate field in FISS.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor MCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a report of all inpatient claims paid without processing through the MCE with the exception of override situations explained in the Note above (e.g., for limited coverage edits). The list of claims paid outside of the MCE is to include the following information:

    - HIC
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports. Send a copy of the summary data to: Centers for Medicare and Medicaid Services, Division of Institutional Claims Processing, Mailstop C4-10-07, 7500 Security Blvd. Baltimore, MD 21244-1850.

20.2.2 - DRG GROUPER Program

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The FI pays for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. The DRG weights used to calculate payment are in the Pricer DRGX file.

The FI uses the GROUPER program to assign the DRG number. GROUPER determines the DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the FI or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the DRG price. GROUPER input/output are specified below. The FI determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1 - Principal and up to eight other ICD-9-CM diagnoses

2 - Principal and up to five additional ICD-9-CM procedures

3 - Age at last birthday at admission

4 - Sex (1=male and 2=female)

5 - Discharge destination (patient status code from the claim)

The claim sex coding is M for male and F for female while GROUPER is l for male and 2 for female. Discharge destination codes are similar to claim definitions for patient status except codes 20-29 are summarized as 20. The FI calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1 - Major diagnostic category

2 - DRG number

3 - Grouper return code (a one position code indicating the action taken by the program)

4 - Procedure code used in determining the DRG

5 - Diagnosis code used in determining the DRG

6 - Secondary diagnosis code used in determining the DRG, if applicable

20.2.3 - PPS Pricer Program
(Rev. 1, 10-01-03)

A3-3615.3, A3-3656.3

The CMS provides a Pricer program to determine the price upon which to base payment under prospective payment. A separate Pricer installation guide is provided. The FI uses the Pricer appropriate for the date of discharge.

After GROUPER determines the DRG, the FI's system calls the Pricer program. Pricer determines the price to pay and prepares a report.

Four data files are included. CMS maintains three:

- DRGX file - contains DRG weights, average length of stay and outlier cutoff points.

- MSAX file - contains urban and rural wage indexes used in calculating payment. CMS may request that the FI make interim changes to this file when index changes are issued for individual hospitals after issuance of Pricer for the period.

- RATE file - contains census division values and updating amounts used in calculating payment.

The FI maintains the provider-specific file, (PROV file). This contains information about the facts specific to the provider that affect computations, e.g., effective dates for PPS, type of provider (for application of special computation rules), census division, MSA, adjusted cost per discharge, disproportionate share adjustment percentage, and capital data.

Pricer also calculates the disproportionate share adjustment and adds it to the DRG payment. Correct calculation depends upon the accuracy of related information the FI includes in the PRICER PROV file.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, provider-specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Pricer uses the Intern-to-Bed ratio in calculating the indirect teaching adjustment for operating costs for the FI to accumulate and use in related payments. Pricer uses the intern-to-average daily census ratio to calculate the indirect teaching adjustment for capital costs. The FI ensures that these ratios are available for Pricer to compute payment for

teaching hospitals. It includes the ratios in its PROV file to ensure that cost outliers are not overpaid to its teaching hospitals.

Pricer does not calculate utilization days required for the PS&R, CWF, or cost report. It does not determine the amount to pay after deduction for deductible, coinsurance, or the primary payment where Medicare is secondary. The FI must calculate the price and make adjustments to the price furnished before making payment.

The FIs use the Pricer implementation guide for information concerning Pricer processing reports, input parameters and data requirements.

20.2.3.1 - Provider-Specific File

(Rev. 981, Issued: 06-15-06; Effective: 07-01-06; Implementation: 07-03-06)

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI 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 FI 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 FIs 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 FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

The FIs 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: FIs 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 FI 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 FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI

includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals

The FIs 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 FIs 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 FIs 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.

D. Skilled Nursing Facility (SNF)

The FIs 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 FIs 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 FIs create a provider specific history file using the following data elements for each HHA. Regional home health FIs (RHHIs) 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 FIs 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. FIs 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.

G. Long Term Care Hospital (LTCH)

The FIs 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. FIs 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.

H. Inpatient Psychiatric Facilities (IPF)

The FIs 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 FIs 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.

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. FIs must set up an NDM transfer from the FI's 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 FI'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 - Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

(Rev. 1479; Issued: 03-14-08; Effective: 04-01-08; Implementation: 04-07-08)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients.

Adjustments are made in the Federal portion of the operating cost DRG payment to increase payments to hospitals serving a disproportionate share of low-income patients. The additional payment equals the Federal portion of the operating cost DRG payment and outlier payments, but excludes any additional payments for the costs of indirect medical education multiplied by an adjustment percentage.

If a hospital meets the disproportionate share hospital (DSH) definition, an additional operating cost payment will be made for discharges occurring on or after May 1, 1986. The DSH adjustment is applied only to the Federal portion of the operating cost DRG payment (including outlier payments). It is basically a year-end lump sum adjustment. However, the FI will identify hospitals that are eligible to receive the DSH adjustment and make interim payments subject to a year-end settlement based upon the hospital's DSH percentage for the cost reporting period. The DRG payment a hospital receives includes the interim operating cost DSH payment and an interim operating indirect medical education adjustment.

For services on or after October 1, 1997, the DSH percentage is not applied to outlier payments.

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for IPPS hospitals is located at the following CMS web address:

http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage

The data is used for settlement purposes for hospitals.

Note that CMS issues a Recurring Update Notification prior to the Federal Fiscal Year beginning date to provide contractors with the updated SSI file information.

A. Regular Calculation of DSH Percentage

The operating DSH percentage is the sum of:

- The percentage of the hospital's total Medicare Part A patient days attributable to Medicare patients who are also SSI recipients (this percentage will be supplied to the FI by CMS). Since the SSI/Medicare percentages are determined by CMS on a fiscal year basis, hospitals will be afforded the option (for settlement purposes) of determining their SSI/Medicare percentage based upon data from their own cost reporting period. If a hospital avails itself of this option, it must furnish its FI, in a manner and format prescribed by CMS, data on its Medicare patients for the cost reporting period. CMS will match these data to data supplied by SSA to determine the patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period. The hospital bears the full cost of this process, including the cost of verification by SSA.

Consistent with the regulations at 42 CFR 412.106(b)(2)(i) and 412.106(b)(2)(iii), patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111) which includes Condition Code 04 to their Medicare contractor. This will ensure that these days are included in the hospital's SSI ratio for Fiscal Year 2007 and beyond.

For MA patients, Inpatient Rehabilitation Facilities and Long Term Care Hospitals are also required to submit informational only bills (TOB 111) with both Condition Code 04 and a default Case Mix Group (CMG) of A9999.

(Teaching hospitals do not need to submit additional claims with Condition Code 04 as they already submit claims for Indirect Medical Education for MA beneficiaries with Condition Codes 04 and 69. We will capture SSI information from these claims.)

- The percentage of total patient days attributable to patients entitled to Medicaid, but not to Medicare Part A. (Medicaid days and total days are available on the cost report.)

For operating DSH payments:

For discharges between May 1, 1986, and March 31, 1990, a hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds;
- At least 40 percent for an urban hospital with less than 100 beds; or
- At least 45 percent for a rural hospital, with fewer than 500 beds.

For discharges on and after October 1, 1986, the hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of at least 15 percent, is located in a rural area, and has 500 or more beds.

For discharges between April 1, 1990 and December 31, 1995, a hospital qualifies for an operating DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds;
- At least 40 percent for an urban hospital with fewer than 100 beds;
- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as a sole community hospital; or
- At least 30 percent for a rural hospital with more than 100 beds which is classified as a sole community hospital.

A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a DSH percentage greater than 0.

For the DSH determination, the number of beds in a hospital is determined by counting the number of inpatient care bed days available during the cost reporting period, excluding beds assigned to newborns, custodial care, and PPS excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period. Inpatient care bed days available should be the same as Indirect Medical Education (IME) bed days. Available beds may not match the number of licensed beds.

B. Determination of Operating DSH Adjustment Percentage

Hospitals that meet the DSH percentage criteria are entitled to adjustments to the Federal portion of their operating cost DRG payments (including the Federal portion of outlier payments) as follows. For hospitals that qualify for DSH payment, Pricer calculates the DSH adjustment percentage. (See §20.2.3.) The following procedures are used to calculate the DSH adjustment.

For the period May 1, 1986 - September 30, 1988:

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds - The lesser of 15 percent or the percentage determined by using the following formula:

(DSH % - 15)(.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21. Its DSH payment factor is computed:

(21 - 15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45. Its DSH payment adjustment factor is computed:

(45 - 15)(.5) + 2.5 = 17.5%

DSH adjustment factor = 15% (.1500) (the maximum adjustment under the law)

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period October 1, 1988 - March 31, 1990:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds** - the following formula is used:

  (DSH % - 15) (.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its DSH payment factor is computed:

(21-15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its DSH payment adjustment factor is computed:

(45-15) (.5) + 2.5 = 17.5%

DSH adjustment factor = 17.5% (.1750, the limit was removed effective 10/1/88)

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period April 1, 1990 - December 31, 1995:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the following formula is used:

  Through December 31, 1990 - (DSH % - 20.2) (.65) + 5.62

  January 1, 1991, and later - (DSH % - 20.2) (.7) + 5.62

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its December 1990 DSH payment factor is computed:

(21 - 20.2) (.65) + 5.62 = 6.14%

DSH adjustment factor = 6.14% (.0614)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its December 1990 DSH payment adjustment factor is computed:

(45 - 20.2) (.65) + 5.62% = 21.74%

DSH adjustment factor = 21.74% (.2174)

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is equal to or less than 20.2 - the following formula is used:

(DSH % - 15) (.6) + 2.5

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital, and has a DSH percentage of 35 percent. Its DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000)

Hospital D is a rural hospital which is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor is 13% (.1300)

- **Rural hospitals that are RRCs, but are not sole community hospitals**-the following formula is used:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals, but are not RRCs** - 10 percent.

- **Rural hospitals not described above with 100 beds or less** - 4 percent if DSH percentage is 45 percent or more.

- **Rural hospitals not described above with more than 100 beds but fewer than 500 beds** - 4 percent if DSH percentage is 30 percent or more.

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5

For the period October 1, 1993, through September 30, 1994:

- **Urban hospitals with 100 or more beds whose DSH percentage is greater than 20.2**-the following formula is used:

(DSH % - 20.2) (.8) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5
- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 35 percent. The DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater payment

Hospital D is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

Rural hospitals that are RRCs and are not sole community hospitals - the percentage is determined using the following formula:

(DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

For discharges after September 30, 1994:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the percentage is determined using the following formula:

  (DSH % - 20.2) (.825) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.65) + 2.5

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined with the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 35 percent. Its October 1994 DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater rate

Hospital D is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its October 1994 DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

- **Rural hospitals that are RRCs, but not sole community hospitals** - Use the following formula:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

The amount of the operating cost DSH adjustment is computed by multiplying the Federal portion of the hospital's operating cost DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (.0550). The Federal portion of its DRG revenues including appropriate outlier payments, but excluding any payments for indirect medical education costs, equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

The FI will accumulate a record of the DSH amount paid, the Federal portion of the operating cost DRG and any outlier amount for hospital discharges after April 30, 1986, to use at cost settlement.

C. Computation of DSH Adjustment

Compute the amount of the DSH adjustment by multiplying the Federal portion of the hospital's DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (or .0550). The Federal portion of its DRG revenues (including appropriate outlier payments, but excluding any payments for indirect medical education costs) equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

D. DSH Exception

The law contains a provision whereby a hospital can qualify for an operating cost DSH adjustment of:

- 15 percent for discharges prior to October 1, 1988;
- 25 percent for discharges between October 1, 1988, and April 1, 1990;
- 30 percent for discharges from April 1, 1990, through September 31, 1991;
- 35 percent for discharges on or after October 1, 1991, if:
    - It is located in an urban area and has 100 or more beds; and
    - It demonstrates that, during its cost reporting period, more than 30 percent of its total inpatient care revenues were derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

It is incumbent upon the hospital to demonstrate that more than 30 percent of its total inpatient care revenues are from State and local government sources and that they are specifically earmarked for the care of indigents (that is, none of the money may be used for any purpose other than indigent care). The following are the types of care that are not included as indigent care:

- Free care furnished to satisfy a hospitals Hill-Burton obligation.

- Free care or care a hospital furnished at reduced rates to its employees or by a government hospital to any category of public employee.

- Funds furnished to a hospital to cover general operating deficits.

- The adjustment is not automatic from year to year but must be applied for on an annual basis.

Documentation to support the application includes the hospital's complete audited financial statements and their accompanying notes. The hospital must provide detailed schedules related to State and local revenue appropriations and outline their purpose.

Unless the appropriations are specifically earmarked for indigent patient care, the FI will assume that a portion of the funds was intended to cover the costs of other uncompensated care, such as bad debts for non-indigent patients, free care to employees, etc., as well as to cover general operating deficits. The FI will calculate the percentage of charity care included in all uncompensated care and apply the percentage to the appropriate funds to determine the amount appropriated for charity care.

Hospitals must submit documentation to support amounts claimed as indigent patient care. This includes a copy of their procedures for determining indigence, steps used to verify a patient's financial information, and methods used to distinguish bad debts from indigence.

The FI is responsible for reviewing the documentation submitted in support of the provider's request for a disproportionate share adjustment under 42 CFR 412.106(c)(2) of the regulations. This review can be accomplished in conjunction with the audit/settlement of the cost report for the period subject to the adjustment. At a minimum, the FI must:

- Verify total inpatient revenues;

- Verify that State and local government appropriations on the financial statements are consistent with amounts contained in governmental appropriations bills;

- Review, on the basis of a sample of cases, the provider's implementation of procedures for identifying indigent patients. Ensure that amounts for "indigent" patients do not include charges associated with:

    ° Titles XIX and XVIII patient care;

    ° Hill-Burton care;

    ° Free care to employees; and

    ° Bad debts for patients who are not indigent.

E. Reporting for PS&R and CWF

The FI's PPS Pricer identifies the amount of the DSH adjustment on each bill. The FI reports this amount with value code 18 to its PS&R, and to CWF.

20.3.1 - Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation
(Rev. 1, 10-01-03)

20.3.1.1 - Clarification for Cost Reporting Periods Beginning On or After January 1, 2000
(Rev. 1, 10-01-03)

PM A-01-03

Under §1886(d)(5)(F) of the Social Security Act (the Act), the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the

patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. Please see the chart in 140.2.4.1, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted.

20.3.1.2 - Hold Harmless for Cost Reporting Periods Beginning Before January 1, 2000

(Rev. 1, 10-01-03)

In accordance with the hold harmless position communicated by CMS on October 15, 1999, for cost reporting periods beginning before January 1, 2000, hospitals are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula. This is consistent with CMS' determination that hospitals and FIs relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or FIs. Although CMS has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue

In practical terms this means that the FI is not to reopen any cost reports for cost reporting periods beginning before January 1, 2000, to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports. If, prior to the issuance of this Program Memorandum, a hospital reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts (including interest) collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance. Furthermore, on or after October 15, 1999, the FI is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

For cost reporting periods beginning before January 1, 2000, hospitals are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999, (i.e., for open cost reports, the FI allows only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, the FI is to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that the FI allows for the open cost reports must be supported by auditable documentation provided by the hospital.

Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue

If a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, the FI is not to pay the hospital based on the inclusion of these types of days for any open cost reports for cost reporting periods beginning before January 1, 2000. Furthermore, on or after October 15, 1999, the FI is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, the FI will reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. If there are any questions or concerns regarding the qualifications for a "jurisdictionally proper appeal," the FI submits them in writing before rendering a decision in a specific case to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Office of Financial Management
Financial Services Group
Location C3-14-16
Baltimore, Maryland 21244-1850.

Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that are used in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

Continue to pay the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

Finally, if a hospital has filed a jurisdictionally proper appeal with respect to the CMS 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the CMS 97-2 appeal.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.	No.
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan.	No.
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No.
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under	Yes.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
	the authority of these provisions, which is exercised by the State in the context of the approved State plan.	
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes.
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
§1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes.
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes.
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.	Yes.
Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No.

20.3.2 - Updates to the Federal Fiscal Year (FY) 2001

(Rev. 1, 10-01-03)

PM A-01-47

20.3.2.1 - Inpatient Hospital Payments and Disproportionate Share Hospital (DSH) Thresholds and Adjustments
(Rev. 1, 10-01-03)

The new FY 2001 operating standardized amounts are effective April 1, 2001, as required by §301 of BIPA 2000 (P.L. 106-554), and the new DSH thresholds and adjustments are required by §211 of BIPA 2000. In conjunction with the new standardized amount, the new capital rates and outlier adjustment factor thresholds are effective April 1, 2001.

The following standardized amounts effective for discharges occurring on or after April 1, 2001, and before October 1, 2001, are:

Final FY 2001 Operating Rates

	Large Urban Areas		Other Areas	
	Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
+National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	$2,900.64	$1,179.02	$2,900.64	$1,179.02
Puerto Rico	$1,402.79	$564.66	$1,380.58	$555.72
SCHs	$2,895.02	$1,176.74	$2,849.20	$ 1,158.11

Final FY 2001 Capital Rates

National	$380.85
Puerto Rico	$184.61

Due to the changes to the standardized amounts, CMS recalculated the fixed loss cost outlier threshold applicable for discharges on or after April 1, 2001, and before October 1, 2001. The new thresholds are equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs).

In addition, §211 of BIPA 2000 revised the thresholds by which certain classes of hospitals qualify for the disproportionate share adjustment, effective for discharges occurring on or after April 1, 2001. Section 211 also revised the adjustment computations for these hospitals.

The specific changes are identified below.

Urban Hospitals	Qualifying DSH Percent	Adjustment Computation

0-99 Beds	≥15%, <19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15)] 5.25%
100+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	≥15%, <19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 10%
Rural Referral Centers (RRC)	≥15%,<19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 5.25% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	≥15%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-499Beds	≥15%,<19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
500+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct. -20.2%)]

These new rates as well as changes to the DSH adjustments are incorporated into Pricer 01.2. The formulas are spelled out in the statute.

20.3.3 – Prospective Payment Changes for Fiscal Year (FY) 2003

(Rev. 1, 10-01-03)
A-02-084

The PPS changes for FY2003 were published in the Federal Register on August 1, 2002. All changes are effective for hospital discharges occurring on or after October 1, 2002, unless otherwise noted.

ICD-9-CM coding changes are effective October 1, 2002. The new ICD-9-CM codes are listed, along with their diagnosis-related group (DRG) classifications in Tables 6a and 6b in the final rule for PPS changes for FY 2003. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f of the same final rule. GROUPER 20.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2002. Medicare Code Editor (MCE) 19.0 and Outpatient Code Editor (OCE) versions 18.0 and 3.20 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2002.

Additional changes for FY 2003 are:

- The standardized amount update factor is 2.95 percent for all hospitals.
- The hospital specific update factor is 2.95 percent for all hospitals.

- The common fixed loss cost outlier threshold in FY 2003 is equal to the PPS rate for the DRG, Indirect Medical Education (IME), and Disproportionate Share Hospital (DSH) plus $33,560.

- The marginal cost factor for cost outliers remains 80 percent.

- The 2003 Federal capital rate is $407.01 and the Puerto Rico capital rate is $198.29.

- The FY 2003 outlier adjustment factor is 0.948999 for the operating standardized amount.

- The FY 2003 outlier adjustment factor for Puerto Rico is 0.981651 for the operating standardized amount. Also new for FY 03, there is an outlier adjustment factor of 0.965325 for operating national/Puerto Rican blend.

- Payments under the DSH provision are not reduced in FY 2003.

- The IME formula is 1.35*[(1+ resident-to-bed ratio)**. 405-1] for FY 2003.

- The revised hospital wage indexes and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the PPS final rule.

- Grouper 20.0 and MCE 19.0 for discharges occurring on or after October 1, 2002 replace earlier versions of the software.

See Addendum: Hospital Reclassifications and Redesignations by Individual Hospital – FY2003.

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

(Rev. 73, 01-23-04)

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).

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.

20.4 - Hospital Capital Payments Under PPS

(Rev. 1, 10-01-03)

A3-3611

The Omnibus Budget Reconciliation Act of 1987 established an effective date of October 1, 1991, for capital PPS. Capital PPS will pay hospitals a fixed amount for each Medicare admission upon completion of a 10-year transition period.

Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs. They continue to be paid for capital-related costs on a reasonable cost basis.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to PPS for operating costs. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines in §§40, also apply to capital PPS payments. Outlier thresholds and computation methods have been combined effective with FY 1993 for operating and capital costs.

Capital transfer cases are paid on a per diem basis analogous to the manner in which operating PPS payments are made for transfer cases.

Beneficiary deductible and coinsurance obligations do not apply to capital costs. Ancillary costs paid under Part B do not impact capital PPS payments. The 10-year transition period was established to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. These high capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national rate for those hospitals with capital obligations that are less than the national rate.

A combined payment is made for both operating costs and capital costs under PPS, but the value of the payment for each must be separately identified in the remittance advice for accounting purposes.

20.4.1 - Federal Rate

(Rev. 1, 10-01-03)

A3-3611.1

The standard Federal capital payment for FY 1992 and later years is based on the projected national average Medicare capital costs per discharge for each of the fiscal years. The Federal rate is adjusted for each hospital's case mix, day and cost outliers and wage index location. A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a disproportionate share (DSH) percentage greater than 0.

The Federal rate is adjusted annually to reflect changes in these factors.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. The FI calculates the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the CMS Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the cost reporting period.) It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.2 - Hold Harmless Payments
(Rev. 1, 10-01-03)

A3-3611.2

In FY 1992, hospitals with a hospital-specific rate for capital that is above the Federal PPS rate for the cost reporting period that ended in FY 1990 can receive the higher of:

- The hold harmless-old capital rate, which is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital (see §20.4.5 for the definitions of old and new capital); or

- The hold harmless - 100 percent Federal rate.

The FI adjusts the hospital-specific rate in the cost report for the period ending in FY 1990 for case mix. It updates the rate to FY 1992 levels using the projected increase in national average capital costs per discharge to initially determine whether a hospital should be paid under the hold harmless or the fully prospective methodology. The type of methodology is entered in the provider-specific file. (See §20.2.3.)

Hospitals paid under the fully prospective methodology may change to the hold harmless methodology if justified by the addition of obligated capital and other changes in remaining old capital costs subsequent to the base period. This option is available through the later of a hospital's cost reporting period beginning in FY 94 or after obligated capital has been put in use. Hospitals must request an extension from the FI by the later of January 1, 1993, or within 180 days of the event causing the delay, if they will be unable to put an asset in use for inpatient care by October 1, 1996. The new hospital-specific rate reflects the disposal of old assets and the addition of obligated capital costs, but not new capital acquisitions. If the recalculated hospital-specific rate exceeds the Federal rate, the hospital will be paid under the hold harmless methodology. The payment methodology in effect for FY 94 (or after the obligated capital has been put in use, if later) determines the payment methodology applicable for the remainder of the transition period under either transition payment methodology.

The FI does not hold harmless a hospital for increased costs resulting from a lease arrangement entered into after December 31, 1990.

If a hospital has such low Medicare utilization in its original capital base period that it is not required to file a cost report, its hospital-specific rate will be based on its old capital costs per discharge in the first 12-month cost reporting period for which a cost report is filed.

The FI converts a reasonable cost/hold harmless hospital to the 100 percent Federal payment rate when:

- Advantageous due to reductions in depreciation and/or the allowable percentage of old capital;
- A hospital elects to be paid at 100 percent of the Federal rate; or
- A hospital does not maintain adequate records to identify its old capital related costs.

The FI enters the payment methodology change in the provider-specific file.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. The FI calculates the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the CMS Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the cost reporting period). It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.3 - Blended Payments
(Rev. 1, 10-01-03)

A3-3611.3

Hospitals with a FY 1990 hospital-specific rate for capital below the Federal rate are paid a fully prospective capital rate based on a blend of their hospital-specific rate and the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1992 is based on a blend of 90 percent of the hospital-specific rate and 10 percent of the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1993 is based on a blend of 80 percent of the hospital-specific rate and 20 percent of the Federal rate. The Federal portion of the payment increases by 10 percent each year and the hospital-specific portions decreases by 10 percent each year, culminating in payment at 100 percent of the Federal rate in the tenth year.

20.4.4 - Capital Payments in Puerto Rico
(Rev. 1, 10-01-03)

A3-3611.4

A special standard rate applies to Puerto Rico. It is a combination of 50 percent of the Federal capital amount and 50 percent of the Puerto Rican capital amount. It is used in lieu of the Federal rate to compute hold harmless and fully prospective payments for PPS hospitals in Puerto Rico.

20.4.5 - Old and New Capital
(Rev. 1, 10-01-03)

A3-3611.5

Old capital is a hospital asset that:

- Has been put in use for patient care on or before December 31, 1990; or

- Has been legally committed to by an enforceable contract entered into on or before December 31, 1990, and put in patient use before October 1, 1994.

All other assets are considered new for Medicare purposes.

20.4.6 - New Hospitals
(Rev. 1, 10-01-03)

A3-3611.6

New hospitals that open during the national 10-year transition are exempt from capital PPS payment for their first two years of operation. A new hospital is one that does not have a 12-month cost reporting period that ended on or before September 30, 1990. The new hospital exemption does not apply to:

- A new acute care hospital that operated as a PPS excluded hospital for 2 or more years before its transition to PPS;
-
- A hospital which has been open more than 2 years, but has participated in Medicare fewer than 2 years;

- A hospital that closes and reopens within 2 years under the same or different ownership; or

- A hospital that builds a new or replacement facility at the same or a new location, even if a change of ownership or new leasing arrangements are involved.

A new hospital is paid 85 percent of its reasonable costs for capital during the exemption period. The hospital's second year of operation is the base period for determination of the hospital-specific rate and old capital assets. Effective with its third year of operation, the hospital is paid:

- The fully prospective methodology if the hospital-specific rate is less than the Federal rate. The FI uses the blend rate applicable to the Federal FY in which the base period begins. For example, a new hospital with a hospital-specific rate less than the Federal rate and a base year beginning in FY 1995 is paid 70 percent of its hospital-specific rate and 30 percent of the Federal rate; or

- The hold harmless methodology if the hospital-specific rate is greater than the Federal rate. Hold harmless payments may continue for up to 8 years. They may continue beyond the first cost reporting period that begins on or after October 1, 2000.

20.4.7 - Capital PPS Exception Payments
(Rev. 1, 10-01-03)

A3-3611.7, 42 CFR 412.348

Exception payments are provided for hospitals with inordinately high levels of capital obligations. Payment is made to a hospital paid under either the fully prospective payment methodology, or the hold-harmless payment methodology. Exception payments will expire at the end of the 10-year transition period. Exception payments ensure that:

- Sole community hospitals receive 90 percent of their Medicare inpatient capital costs;

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and

- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

Pricer adds interim exception payments to the basic capital payment, using the rate entered in positions 189-194 of the provider-specific file. The FI adjusts these interim payments, as needed, at cost report settlement.

A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount.

A limited exception is also provided during the 10-year transition period for hospitals that experience unanticipated extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) to qualify for this exception. An eligible hospital's minimum payment level under this exception is 85 percent of costs associated with the unanticipated capital expenditure and the applicable minimum payment level for its other Medicare inpatient capital costs.

Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

These limited exceptions must be approved by CMS prior to payment. If approved, the FI includes the limited exception payment amount per discharge in the exception field of the provider specific file.

20.4.8 - Capital Outliers
(Rev. 1, 10-01-03)

A3-3611.8

Total Federal PPS payments are reduced by an amount equal to anticipated outlier payments for the year to fund capital and operating outlier payments. Outlier payments apply only to the Federal portions of capital payments. Pricer calculates outlier payments.

Pricer used a combined methodology to determine the day outlier payment rate for capital and operating day outliers (**Day outliers were eliminated after FY 1997**). A second combined methodology is used to determine the cost outlier payment rate for capital and operating costs. A capital or operating cost outlier is paid only if both capital and operating costs related to an admission exceed the combined outlier threshold. Pricer pays the higher of the combined total cost outlier payment or the total day outlier payment. An exception applies to a transferring hospital. A transferring hospital may be paid a cost outlier, but may not be paid a day outlier unless DRG 385 or 456 applies. The outlier computation methodology is contained in the FI Pricer installation guide. (See §20.7 for the common thresholds that apply to both operating and capital outliers.)

20.4.9 - Admission Prior to and Discharge After Capital PPS Implementation Date
(Rev. 1, 10-01-03)

A3-3611.9

The capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable

cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS. The FI may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period.

It bases any outlier payment due on the entire stay, not only that portion of the stay that began after the start of capital PPS.

20.4.10 - Market Basket Update
(Rev. 1, 10-01-03)

A3-3611.10

For FY 1992 through FY 1995, the update to the Federal and the hospital-specific rates is based on actual increases in capital-related costs per discharge adjusted for case mix change. For example, FY 1993 rate updates are based on a comparison of inpatient capital costs per case in Medicare cost reports beginning in FY 1990 and the costs per case in the cost reports beginning in FY 1988. The update computation will be modified after FY 1995 to reflect the capital market basket index, changes in capital requirements and new technology. Annual updates for periods after FY 1992 will be effective October 1 for all PPS hospitals, rather than the start of cost report periods that begin during that FY.

20.5 - Rural Referral Centers (RRCs)
(Rev. 1, 10-01-03)

A3-3610.16, HO-415.17

Section 1886(d)(5)(C) of the Act provides for exceptions and adjustments to the standardized prospective payment amounts to take into account the special needs of RRCs. The adjustment allowed for approved RRCs is that they are paid based upon the urban, rather than rural, prospective payment rates as adjusted by the applicable DRG weighting factor and the rural area index. In addition, OBRA 89 (P.L. 101-239) extended RRC status through cost reporting periods beginning before October 1992 to any hospital classified as an RRC as of September 30, 1989.

To retain status as an RRC effective with the cost reporting period beginning on or after October 1, 1992, a hospital must have met the criteria for classification as an RRC in at least two of the prior three years, or qualify on the basis of the requirements for initial RRC certification for the current year. The FI will not review the RRC status of a hospital before the end of its third full cost reporting year as an RRC. It will limit review of RRCs in operation more than three years at the beginning of FY 1993 to a hospital's most recent three years. RRCs that pass review as meeting RRC status for at least two of the last three years receive a 3-year extension of their RRC status.

The rates in Pricer include a reduction in the adjusted standardized amounts for all hospitals to ensure that total PPS payment neither increase nor decrease as a result of the increase in payments to RRCs.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 1992, a rural hospital must have had at least 275 beds, or the hospital must have met one of three criteria in 42 CFR 412.96(c) (3), (4) and (5), and both of the following requirements:

- The hospital's case-mix index value for FY 91 must have been at least 1.2760, or equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located, if fewer.

- For its cost reporting period that began during FY 1991, the hospital must have had at least 5000 discharges, or equal to the median number of discharges for urban hospitals in that census region, if fewer, or if an osteopathic hospital, must have had at least 3000 discharges.

The CMS publishes the median case-mix index value and the median number of discharges annually in the PPS update in the "Federal Register."

20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

(Rev. 1, 10-01-03)

A3-3610.17, HO-415.18

A. Criteria for Sole Community Hospitals (SCHs)

For cost reporting periods beginning on or after October 1, 1989, an SCH is a rural hospital that meets one of the following:

- Located more than 35 miles from other like hospitals;

- Located between 25 and 35 miles from other like hospitals; and;

    - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located with a 35-mile radius of the hospital, or if larger, within its service area;

    - Has fewer than 50 beds and would admit at least 75 percent of the inpatients from its service area except that some patients seek specialized care unavailable at the hospital; or

    - Other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years because of local topography or prolonged or severe weather conditions.

- Located between 15 and 35 miles from other like hospitals, but because of local topography or prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

- Effective October 1, 1990, because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Any SCH that qualified under the prior criteria that would lose eligibility under the new criteria, retains its status as a SCH.

An urban hospital more than 35 miles from other like hospitals is also considered a SCH.

B. Criteria for Medicare Dependent Hospitals (MDHs)

For cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993, an MDH is a rural hospital that met all of the following:

- Had 100 or fewer beds;

- Was not classified as an SCH; and

- For its cost reporting period that began during FY 87, was dependent on Medicare for at least 60 percent of its inpatient days or discharges.

C. Payment to SCHs and MDHs

Hospitals are paid based on the highest of the following rates:

- The Federal rate applicable to the hospital;

- The updated hospital-specific rate based on FY 1982 costs per discharge;

- The updated hospital-specific rate based on FY 1987 costs per discharge;

- A phase-in blended rate of the updated hospital-specific rate based on FY 1982 costs per discharge and a FY 1996 hospital-specific rate; or

- A phase-in blended rate of the updated hospital-specific rate based on FY 1987 costs per discharge and a FY 1996 hospital-specific rate.

For discharges beginning in FY 2004, the additional optional rate would be 100 percent of the FY 1996 hospital-specific rate.

The actual payment amount for each bill is determined by Pricer based upon information the FI maintains in its provider specific file. Review and possible lump sum adjustment applies when the cost report is reviewed.

D. Claims Processing

The FI uses the following provider type codes to enable Pricer to calculate the appropriate rates for these facilities:

- 14 for a MDH that is not an RRC;
- 15 for a MDH that is also an RRC;
- 16 for a rebased SCH that is not an RRC; and
- 17 for a rebased SCH that is also an RRC.

The FI calculates the higher of the 1982 or 1987 adjusted base period costs per discharge (hospital specific rate) and adjusts to the 1990 level. It enters this amount in field 21, position 81-87 effective for the first day of the cost report period beginning April 1, 1990, or later. It enters this even if it expects the hospital to be paid at the Federal PPS rate. Preloading before the effective date is acceptable as long as the correct effective date is used for the record. The FI leaves the field blank if the hospital did not operate in either 1982 or 1987.

Pricer calculates the payment based upon the higher of the Federal rate or the hospital-specific rate in field 21, and where the hospital-specific rate is higher, Pricer reports the amount of the difference in the hospital-specific field. The FI carries this amount forward in the hospital-specific payment field to its PS&R record for use at cost settlement.

20.7 - Billing Applicable to PPS
(Rev. 1, 10-01-03)

20.7.1- Stays Prior to and Discharge After IPPS Implementation Date
(Rev. 1, 10-01-03)

A3-3610.4, HO-415.7

When the admission is before the hospital's PPS effective date and the discharge is later than that date (transition claims), the Medicare payment for the period before PPS is on a reasonable cost basis and the payment for the period after PPS is on a DRG basis.

The hospital must submit two bills. The first bill is for the period before the PPS effective date and is processed and paid in accordance with requirements in effect before the hospital's PPS effective date. The second bill is processed under PPS but the amount of payment on the first bill is subtracted from it. FIs make the adjustment by subtracting the

interim payment from the prospective payment (before any deduction for deductible or coinsurance) for the inpatient operating costs applicable to the days in the prior period. The interim payment applicable to the prior period is adjusted to exclude estimated costs related to capital and direct medical education, kidney acquisition costs, and for bad debts for uncollectible deductible and coinsurance. FIs will make an estimate if necessary.

For hospitals previously receiving interim payment on the basis of an average cost per diem or under PIP, the FI determines and removes a per diem amount for the excluded costs for that period from the interim payments before reducing the prospective payment amount applicable to the discharge in the subsequent period under PPS. Similarly, for hospitals that received a percentage of billed charges, the portion of the percentage applicable to the excluded cost items is removed. The net percentage to the charges billed in the prior period (cut-off bill) is applied. The resulting amount is subtracted from the PPS payment applicable to the discharge in the subsequent period.

For transition claims, payment must not exceed the higher of what would have been paid under PPS including the outlier adjustment **or** any earlier cost payment. The final amount is not reduced to less than zero. No further adjustments are appropriate.

The interim payments used to reduce the prospective payment amounts are considered to represent fairly the inpatient operating costs incurred and fair payment for the portion of the stay occurring in the prior period. Therefore, the adjustment is final and not subject to further modification.

On bills covering two cost reporting periods:

- Each bill includes charges and covered days that apply to the period covered.
- The cut-off bill for the cost period is completed per Chapter 25.

- The PPS bill contains principal diagnosis and surgical procedures for the entire stay.

- The PPS bill shows the admission date, but the period covered begins with the first day of the new accounting year.

- Where discharge is on the first day of the new accounting year, a PPS bill is still due. Some payment may be due the provider, and the open admission must be closed on CMS' records. There are no accommodation charges on the day of discharge; the hospital will report ancillary charges for the day of discharge on the prior bill.

- Coinsurance days and related amounts are applied separately to each bill, i.e., the proper deduction for coinsurance days reported on the second bill is taken from that bill.

20.7.2 - Split Bills

(Rev. 1, 10-01-03)

A3-3610.6, HO-415.9

Under PPS, split billing is not needed for cost reporting purposes; however, it is necessary to show on the bill the coinsurance days in each calendar year for proper application of the coinsurance amount.

For admissions prior to the cost reporting year under IPPS with a discharge after the beginning of the prospective payment year, the DRG payment for the discharge is reduced by the cost of services furnished in the prior period.

The hospital uses the day or charge statistics on the bill representing the portion of the stay in the prior period to determine the cost of the services furnished. Split bills are not needed at the end of the government's fiscal year or the calendar year as changes in DRG prices are determined by the date of discharge. This is shown in value codes 09 (first year coinsurance) and 11 (second year coinsurance). (See Chapter 25.)

PPS days on the cost report are allocated to the year of the discharge. Hospitals not on IPPS, LTCHPPS, or IRFPPS continue to submit split bills at the end of their fiscal years and allocate the days to the hospital year in which they occurred.

When split billing applies, DRG payments are made only on bills that show a discharge date and status. No DRG payment is made on PPS bills that show "still patient" status.

The hospital may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period. Capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS.

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev. 903, Issued: 04-14-06; Effective/Implementation Dates: 07-14-06)

Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factors furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood-

clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

Local carriers shall process non-institutional blood clotting factor claims.

The FIs shall process institutional blood clotting factor claims payable under either Part A or Part B.

A. Inpatient Bills

Under the Inpatient Prospective Payment System (PPS), hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider under special instructions for units of service.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Standard System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2004, this payment is based on 95 percent of average wholesale price.) For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For SNF inpatient Part A, there is no add-on payment for blood clotting factors.

The codes for blood-clotting factors are found on the Medicare Part B Drug Pricing File. This file is distributed on a quarterly basis.

For discharges occurring on or after October 1, 2000, and before December 31, 2005, report HCPCS Q0187 based on 1 billing unit per 1.2 mg. Effective January 1, 2006, HCPCS code J7189 replaces Q0187 and is defined as 1 billing unit per 1 microgram (mcg).

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE 1

HCPCS	Drug	Dosage
J7189	Factor VIIa	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	Drug	Dosage
J9355	Trastuzumab	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	Drug	Dosage
J3100	Tenecteplase	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

At times, the facility provides less than the amount provided in a single use vial and there is waste, i.e.; some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus the amount administered.

Example 1:

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An

appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2:

An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and repeats the HCPCS code. One hundred thousand fifty (100,050) units are reported on one line as 99,999, and another line shows 1,051.

Revenue Code 0636 is used. It requires HCPCS. Some other inpatient drugs continue to be billed without HCPCS codes under pharmacy.

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is also applicable to inpatient Part B services in SNFs and all types of hospitals, including CAHs. Separate payment is not made to SNFs for beneficiaries in an inpatient Part A stay.

B. FI Action

The FI is responsible for the following:

- It accepts HCPCS codes for inpatient services;
- It edits to require HCPCS codes with Revenue Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. It does not edit units except to ensure a numeric value;
- It reduces charges forwarded to Pricer by the charges for hemophilia clotting factors in revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF; and
- It modifies data entry screens to accept HCPCS codes for hospital (including CAH) swing bed, and SNF inpatient claims (bill types 11X, 12X, 18x, 21x and, 22x).

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-9-CM diagnosis code for hemophilia is included on the bill.

Since inpatient blood-clotting factors are covered only for beneficiaries with hemophilia, the FI must ensure that one of the following hemophilia diagnosis codes is listed on the bill before payment is made:

286.0 Congenital factor VIII disorder
286.1 Congenital factor IX disorder
286.2 Congenital factor IX disorder
286.3 Congenital deficiency of other clotting factor
286.4 von Willebrands' disease

Effective for discharges on or after August 1, 2001, payment may also be made if one of the following diagnosis codes is reported:

286.5 Hemorrhagic disorder due to circulating anticoagulants
286.7 Acquired coagulation factor deficiency

C. Part A Remittance Advice

1. X12.835 Ver. 003030M

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment (CAS is the element identifier) exhibiting an "OA" Group Code and adjustment reason code "97" (payment is included in the allowance for the basic service/ procedure) followed by the associated dollar amount (POSITIVE) and units of service. For this version of the 835, "OA" group coded line level CAS segments are informational and are not included in the balancing routine. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier PLB) segment with the provider level adjustment reason code "CA" (Manual claims adjustment) followed by the associated dollar amount (NEGATIVE).

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new PLB adjustment reason code specifically for PIP payment Hemophilia Add On situations for future use. However, continue to use adjustment reason code "CA" until further notice.

The FIs enter MA103 (Hemophilia Add On) in an open MIA (element identifier) remark code data element. This will alert the provider that the reason code 97 and PLB code "CA" adjustments are related to the Hemophilia Add On.

2. X12.835 Ver. 003051

For remittances reporting PIP and/or non-PIP payments, Hemophilia Add On information will be reported in the claim level 2-062-AMT and 2-064-QTY segments. The 2-062-AMTO1 element will carry a “ZK” (Federal Medicare claim MANDATE - Category 1) qualifier code followed by the total claim level Hemophilia Add On amount (POSITIVE). The 2-064QTY01 element will carry a “FL” (Units) qualifier code followed by the number of units approved for the Hemophilia Add On for the claim. The Hemophilia Add On amount will always be included in the 2-010-CLP04 Claim Payment Amount.

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new AMT qualifier code specifically for the Hemophilia Add On for future use. However, continue to use adjustment reason code “ZK” until further notice.

For remittances reporting PIP payments, the Hemophilia Add On will be reported in the provider level adjustment PLB segment with the provider level adjustment reason "ZZ" followed by the associated dollar amount (NEGATIVE).

NOTE: A data maintenance request will be submitted to ANSI ASC X12 for a new PLB, adjustment reason code specifically for the Hemophilia Add On for future use. However, continue to use PLB adjustment reason code "ZZ" until further notice.

The FIs enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and ZZ entries are related to the Hemophilia Add On. (Effective with version 4010 of the 835, report ZK in lieu of FL in the QTY segment.)

3. Standard Hard Copy Remittance Advice

For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

The FIs add the Remark Code “MA103” (Hemophilia Add On) to the remittance advice under the REM column for those claims that qualify for Hemophilia Add On payments.

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ANSI ASC X12N 835, where additional information is available.

See chapter 22, for detailed instructions and definitions.

20.7.4 - Cost Outlier Bills With Benefits Exhausted
(Rev. 1, 10-01-03)

PM - A-99-17 (CR-749)

Providers under IPPS, LTCH PPS, and IRF PPS follow this scenario when benefits are exhausted.

The methodology for using benefit days and reimbursing cost outliers is based on the beneficiary having a lifetime reserve (LTR) benefit day which the beneficiary elects to use or a regular benefit (regular or coinsurance) day beginning the day after the day covered charges are incurred in an amount that results in a cost outlier payment for the provider. Additional charges are considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

DRG claims with cost outlier payments with discharge dates on or after October 1, 1997, must have an Occurrence Code (OC) 47 on the claim unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during Occurrence Span Code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76, or 79 dates. Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available per CWF inquiry or their FI.

Any nonutilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be identified using OSC 70. LTR days should be used as necessary and as elected by the beneficiary. If coinsurance days are exhausted during the inlier portion of the stay and there is a period of nonutilization indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown. When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted. Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted.

Assumptions for all of the following examples:

1. Cost outlier threshold amount is $50,000.

2. Threshold amount is reached on the 25th day.

3. Billed charges are $1,000 each day thereafter.

4. Beneficiary elects to use any available LTR days.

EXAMPLE 1: LTR Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available	30 LTR
Covered days	30
Noncovered days	0
Cost report days	30

All charges for Medicare approved revenue codes billed as covered
No OC 47 needed

Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges

EXAMPLE 2: LTR Days Exhaust in the Cost Outlier

Dates of service:	1/1 - 2/10 discharge
Medically necessary days:	40
Covered charges:	$65,000
Benefits available:	30 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	30

30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges.

OC 47:	1/26
OC A3:	1/30
Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier

EXAMPLE 3: LTR Days Exhaust Prior to Cost Outlier

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	30
Covered charges:	$55,000
Benefits available:	20 LTR
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3	1/25
OSC 70:	1/21 -1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 4: Coinsurance Days Exhaust Prior to Cost Outlier and No LTR Days Are Available

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available:	20 coinsurance
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	1/25
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 5: Coinsurance Days Exhaust Prior to Cost Outlier. LTR Days Exhausts in the Cost Outlier

Date of Service:	1/1 - 2/10 discharge
Medically necessary days	40
Covered charges	$65,000
Benefits available:	20 coinsurance and 10 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	35

35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	2/4
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

EXAMPLE 6: Full and Coinsurance Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge

Medically necessary days	30
Covered charges	$55,000
Benefits available:	10 full and 20 coinsurance
Covered days:	30
Noncovered days:	0
Cost report days:	30

All charges for Medicare approved revenue codes billed as covered.

OC 47:	Not needed
Reimbursement:	Full DRG payment plus cost outlier based on $55,000 covered charges.

EXAMPLE 7: Coinsurance Days and LTR Days Exhaust in the Cost Outlier

Date of Service:	1/1 - 2/28 discharge
Medically necessary days	58
Covered charges	$83,000
Benefits available:	10 full, 30 coinsurance and 10 LTR
Covered days:	50
Noncovered days:	8
Cost report days:	50

50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges

OC 47:	1/26
OC A3:	2/19
Reimbursement:	Full DRG payment, plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

EXAMPLE: 8: LTR Days Exhaust Prior to Cost Outlier and Noncovered Span(s) Present

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	28
OSC 76	1/10 - 1/11
Covered charges:	$55,000
Benefits available:	20 LTR
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/28
OC A3	1/27
OSC 70:	1/23 -1/27
Reimbursement:	Full DRG payment, no cost outlier

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare Advantage (MA) Enrollees

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

During the period January 1, 1998 through December 31, 1998, hospitals received 20 percent of the fee-for-service DGME and operating IME payment. This amount increased by 20 percentage points each consecutive year until it reached 100 percent in calendar year (CY) 2002.

Non-IPPS hospitals and units may submit their MA claims to their respective FIs to be processed as no-pay bills so that the MA inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.

This applies to the following hospitals and units excluded from the IPPS:

- Rehabilitation units
- Psychiatric units
- Rehabilitation hospitals
- Psychiatric hospitals
- Long-term Care hospitals
- Children's hospitals
- Cancer hospitals

In addition, this applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their MA enrollees under 42 CFR §413.87(e). These providers may similarly submit their MA claims to their respective FIs to be processed as no-pay bills so that the MA inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the MA N&AH payment through the cost report.

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular FI with condition codes 04 and 69. The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill to the PS&R report type 118 for MA enrollees in non-IPPS hospitals and non-IPPS units to capture MA inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

The FI submits the claim to the Common Working File (CWF). The CWF determines if

the beneficiary is a MA enrollee and what his/her plan number and effective dates are. The plan must be a MA plan, per 42 CFR §422.4. Upon verification from CWF that the beneficiary is a MA enrollee, the FI adds the MA plan number and an MA Pay Code of "0" to the claim. For fee-for-service claims that were previously paid and posted to history for the same period (due to late posting of MA enrollment data), an L-1002 Automatic Cancellation Adjustment Report will be sent to the FI when a DGME-only or a N&AH-only claim from a non-IPPS hospital or unit is accepted for payment by CWF. No deductible or coinsurance is to be applied against this claim nor is the beneficiary's utilization updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a MA enrollee, CWF rejects the claim and the FI notifies the hospital of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. No interim bills should be submitted for DGME-only or N&AH-only claims and no Medicare Summary Notices should be prepared for these claims.

The DGME payments are made using the same interim payment calculation FIs currently employ. Specifically, FIs must calculate the additional DGME payments using the inpatient days attributable to MA enrollees. As with DGME and N&AH education payments made under fee-for-service, the sum of these interim payment amounts is subject to adjustment upon settlement of the cost report. Note that these DGME and/or N&AH payments apply both to IPPS and non-IPPS hospitals and units.

Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for MA enrollees. The MA inpatient days are recorded on PS&R report type 118. For services provided to MA enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their FI for these cases in accordance with this section's instructions. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report MA inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

30 - Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)

(Rev. 68, 10-16-04)

A3-3610.19, HO-415.19, A3-3610.20, HO-415.20

The Medicare law allows establishment of a Medicare rural hospital flexibility program by any State that has submitted the necessary assurances and complies with the statutory requirements for designation of hospitals as critical access hospitals (CAHs).

To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or

health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, or must be located in a Metropolitan Statistical Area (MSA) of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or critical access hospital unless it is designated by the State, prior to January 1, 2006, to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a length of stay, as determined on an annual average basis, of no longer than 96 hours.

The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by CMS.

A. Grandfathering Existing Facilities

As of October 1, 1997, no new Essential Access Community Hospital (EACH) designations can be made. The EACHs designated by CMS before October 1, 1997, will continue to be paid as sole community hospitals for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. The CAH's length of stay will be calculated by their FI based on patient census data and reported to the CMS regional office (RO). If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS RO, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

1. The facility has been certified as a CAH by CMS;

2. The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and

3. The facility has been granted swing-bed approval by CMS.

A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

1. The facility distinct part unit has been certified as a CAH by CMS;

2. The distinct part unit meets the conditions of participation requirements for hospitals;

3. The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;

4. Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit was established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities in CAHs are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, Section 140 for billing requirements) and the Inpatient Psychiatric Units in CAHs are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);

5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;

6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101

percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply:

- The lesser of costs or charges (LCC) rule;
- Ceilings on hospital operating costs;
- The reasonable compensation equivalent (RCE) limits for physician services to hospitals; and
- The payment window provisions for preadmission services treated as inpatient services under §40.3. (Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient, are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill (85x TOB) from inpatient services. CWF and the shared system shall bypass the CAH provider numbers when applying the edits that compare hospital outpatient and inpatient bills to apply the window provisions. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.)

Low Osmolar Contrast Material (LOCM) furnished as part of medically necessary imaging procedures for inpatients is paid for based on bill type 11X (for LOCM furnished during an inpatient stay covered under Part A), or 12X(for LOCM furnished to an inpatient where payment is under Part B because the stay is not covered under Part A). Bills must include revenue code 636 along with one of the following HCPCS codes as appropriate:

A4644 Supply of low osmolar contrast material (100 – 199 mgs of iodine);

A4645 Supply of low osmolar contrast material (200 – 299 mgs of iodine); or

A4646 Supply of low osmolar contrast material (300 – 399 mgs of iodine).

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirements. Inpatient services should be billed on an 11X type of bill.

30.1.1.1 - Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, Issued 07-23-04, Effective: 01-01-04, Implementation: 01-03-05)

Reimbursement to IHS or Tribal CAHs for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information.

Payment for inpatient IHS or Tribal CAH services is at 100% of the facility specific per diem rate less applicable deductible and coinsurance. Inpatient services should be billed on an 11X type of bill.

Beginning January 1, 2004, IHS or Tribal CAHs are paid 101% of the facility specific per diem rate.

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH
(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The SNF-level services provided by a CAH, are paid at 101% of reasonable cost. Since this is consistent with the reasonable cost principles, FIs **will now** pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

Coinsurance and deductible are applicable for inpatient CAH payment.

All items on Form CMS-1450 are completed in accordance with Chapter 25.

30.1.3 - Costs of Emergency Room On-Call Providers
(Rev. 803, Issued: 01-03-06, Effective: 04-03-06, Implementation: 04-03-06)

For dates of service on or after January 1, 2005, the reasonable costs of outpatient CAH services may include the reasonable compensation and related costs for an emergency room provider who is on call but not present at the premises of the CAH, if the provider is not otherwise furnishing provider services and is not on call at any other provider or facility. The costs are allowable only if they are incurred under a written contract that requires the provider to come to the CAH when the provider's presence is medically required. An emergency room provider must be a doctor of medicine or osteopathy, physician assistant, nurse practitioner, or clinical nurse specialist who is immediately available by telephone or radio contact, and available on site, on a 24-hour a day basis, within 30 minutes, or within 60 minutes in areas described in 42 CFR 1395(g)(5).

For dates of service from October 1, 2001, through December 31, 2004, this provision covers only emergency room physicians. An emergency room physician must be a doctor of medicine or osteopathy.

30.1.4 - Costs of Ambulance Services
(Rev. 1, 10-01-03)

Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or by an entity that is owned and operated by a CAH is, under certain circumstances, the reasonable cost of the CAH or the entity in furnishing those services. Payment is made on this basis only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or

the entity. Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply.

The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

(Rev. 1, 10-01-03)

HO-415.1

A. General

Days of utilization are charged based upon actual days of coverage including grace and waiver days. The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. The hospital collects the coinsurance, if applicable, for only the number of days charged against the beneficiary's utilization record maintained by CMS. For example, if the mean length of stay for a DRG is 10 days and the beneficiary is discharged after 3, only 3 days of utilization is charged. In a like situation, if the DRG mean length of stay is 10 days and the beneficiary is discharged after 15, the 15 days are charged against the utilization record.

NOTE: There are some exceptions to this rule under LTCH PPS. See §150.4.

Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the DRG payment. Days after benefits are exhausted are not charged against the beneficiary's utilization even though the hospital may receive the full DRG payment.

The basic prospective payment amount will be paid if:

- There is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium).

- There is at least l day for which payment may be made under the guarantee of payment. (If benefits are exhausted prior to admission and no payment may be made under guarantee of payment, only Part B benefits are available.)

- The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Utilization is not counted for any days treated as noncovered, except as described below:

- Utilization is not counted for any nonentitlement days, or days after benefits are exhausted (including guarantee of payment days), even if those days are treated as covered for outlier calculation or treated as Medicare patient days for the cost report.

- The length of stay exceeds the day outlier threshold (Day outliers were discontinued at the end of FY 1997), utilization is counted for medically unnecessary days which are noncovered but for which the hospital may not charge the beneficiary because the requirements of §40.2 were not met. See §40.2.2 for identification of these days.

- If the adjusted cost of the stay exceeds the cost outlier threshold, utilization is counted for any medically unnecessary days on which all Part A services are treated as noncovered under §40.2.B and for which the hospital may not charge the beneficiary. (Where only ancillary services are denied, all days are counted as covered.)

Lifetime reserve days for an inpatient hospital stay for which prospective payment may be made is subject to the following:

- If the beneficiary had one or more regular benefit days remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the nonoutlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. After regular benefits have been exhausted, lifetime reserve days will be used automatically for outlier days unless the beneficiary elects not to use them, or the average daily charges for outlier days to be reimbursed as lifetime reserve days do not exceed the lifetime reserve day coinsurance amount. (In the latter case the beneficiary is deemed to have elected not to use lifetime reserve days for outlier days.) An election not to use lifetime reserve for outlier days applies to all outlier days in an admission.

- If the beneficiary had no regular benefit days remaining when admitted, available lifetime reserve days are used automatically for each day of the stay. Exceptions exist if the beneficiary elects not to use lifetime reserve days, or the charges for which the beneficiary is liable, if electing not use lifetime reserve days, do not exceed the charges for which the beneficiary would be liable if the lifetime reserve days were used. Using lifetime reserve days, the beneficiary would be responsible for the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve

days are available. (In the latter case the beneficiary will be deemed to have elected not to use any lifetime reserve days.)

An election by the beneficiary not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay. A deemed election not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay unless payment may be made under the guarantee of payment.

The number of days for which utilization is charged may be different from the number used in Pricer to compute outlier status or the number of Medicare patient days shown on the cost report.

40.1 - "Day Count" Rules for All Providers
(Rev. 1, 10-01-03)

A3-3620

See §40.2.A for general rules on counting days.

A. Day of Admission

For all hospitals, the FI counts the day of admission for the cost report and for utilization. For PPS hospitals, it counts the day of admission for Pricer purposes unless the rules for same day transfer apply.

B. Day of Discharge, Death, or Beginning a Leave of Absence

The FI does not count the day of discharge or death for cost report, utilization or Pricer purposes unless the admission and discharge day are the same day. Where admission and discharge occur on the same day, it counts one day for cost report, utilization and Pricer purposes. If the patient is admitted with the expectation that the patient will remain overnight, but is discharged or dies before midnight, it counts the day for the cost report, utilization and Pricer. It does not count any days in a leave of absence (occurrence span code 74), for cost report, utilization or Pricer purposes.

C. Same Day Transfer From Participating Hospital to Nonparticipating Hospital or Nonparticipating Distinct Part of Hospital

If the beneficiary is admitted to a PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight, the FI counts the day for the cost report, utilization and Pricer. If the beneficiary is admitted to a non-PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating hospital or a nonparticipating distinct part of a hospital before midnight, the FI counts the day for cost report and utilization purposes.

D. Same Day Transfer From Participating Hospital to Participating Hospital

If the beneficiary is transferred to a participating hospital or distinct part of a participating hospital, the FI counts the day, if it is determined to be covered, for the cost report and for Pricer at both hospitals. However, it charges utilization on the bill only for the later admission to avoid charging the beneficiary twice for the same day. The earlier admission, for which the FI does not charge utilization, can be recognized by condition code 40 (same day transfer), and the same date entered in the "From" and "Through" dates in CWF.

E. Guarantee of Payment Days

There can be up to fourteen guarantee of payment days (8 days plus weekends and Federal holidays) beginning with the date in occurrence code 20. The FI does not charge utilization, as the beneficiary has no days remaining, but counts guarantee of payment days for the cost report and Pricer.

F. Provider Liability Issue

When the FI or the QIO finds the provider liable, the FI or the QIO determines the cause for provider liability prior to making any decision regarding utilization. If the provider is technically liable, i.e., liable for reasons other than custodial care or medical necessity of the services, the FI shows the dates of provider liability in occurrence span code 77, and counts the days for utilization, but not for cost report or Pricer purposes. If the provider is liable because services were not medically necessary or were custodial care, the FI shows the dates of provider liability in occurrence span code 79 and does not count the days for cost report, utilization or Pricer purposes.

G. Special Rules Which Differ for PPS and Other Providers

If Part A payment may be made for a hospital stay under PPS (i.e., there is at least one Medicare patient day, guarantee of payment day, or day for which the program is liable to the hospital under the limitation of liability provision), the FI treats all days as covered for cost report purposes, except as provided below. It applies this same rule when per diem payments are made to a transferring PPS hospital, whether for all or part of a stay, or when a PPS hospital requests outlier payment, whether or not such payment is made.

For non-PPS hospitals, PPS exempt units and SNFs, it counts the number of days available to the beneficiary for all purposes.

Where outlier status is involved and there are either pre-entitlement days or days after benefits were exhausted, the FI reduces cost report days by the lesser of the number of pre-entitlement/post-benefits exhausted days or the number of days in the stay in excess of the outlier threshold.

1. Length of Stay Does Not Exceed the Day Outlier Threshold (Day outliers discontinued after FY 97)

The FI counts all days (including day of admission, but not the day of discharge or death, unless it is also the day of admission) as covered for cost report and Pricer purposes. It does not count those medically unnecessary days for which the provider meets notice requirements and other conditions for charging the beneficiary. (See §40.2.2 C and D.) It does not count those medically unnecessary days for cost report or Pricer purposes. It counts the actual number of days available to the beneficiary for utilization.

2. Length of Stay Exceeds the Day Outlier Threshold (Day outliers discontinued after FY 97)

The FI counts all days (including the day of admission, but not the day of discharge or death unless it is also the day of admission) in the stay for cost report and Pricer purposes except as follows:

a. Pre-entitlement Days

The FI does not count pre-entitlement days for the cost report or for utilization in non-PPS hospitals, exempt units or SNFs. For PPS hospitals, it does not count pre-entitlement days for utilization or for Pricer. The number of days counted as noncovered for the cost report is limited to the number of days in the stay in excess of the day outlier threshold. To determine which preentitlement days are counted as noncovered, the FI begins at the end of the stay (the day before the day of discharge, death, etc.) and working backward, counts off days identified as pre-entitlement days until it has counted all preentitlement days or, until the number of days counted equals the total number of days in excess of the outlier threshold.

b. Post-Exhaustion of Benefit Days

The FI treats post-exhaustion of benefit days exactly like pre-entitlement days.

To resolve any Medicare Secondary Payor (MSP) issues, see the Medicare Secondary Payer Manual.

40.2 - Determining Covered/Noncovered Days and Charges

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

The CMS must record a day or charge as either covered or noncovered because of the following:

Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care. Days

denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable.

The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made, i.e., provider liable days and charges are not included. Data from the bill payment process are used in preparing the cost report.

The number of days and charges provided to the Pricer program affects the day and cost outlier determinations and the DRG payment amount. Non-PPS provider days are excluded from Pricer consideration.

It is possible to use a different number of days on a single bill for each of the above purposes, although the same number of days will generally apply in actual practice. For example, if the beneficiary had at least 1 day of eligibility remaining at admission, days that occur after benefits are exhausted up through the day outlier threshold for the applicable DRG are counted for cost reporting purposes under IPPS (see section190.12.1 for IPF and section 150.17 for LTCH benefits exhaust claims processing).

A. General Rule on Counting of Days

These following are general rules for counting days. However, these rules are also subject to special rules for determining day of admission, discharge, death, beginning a leave of absence, same day transfer, guarantee of payment days, provider liability issues and outlier days for PPS outliers. See §40.1 and §40.1.G for an explanation of these special rules.

The provider calculates and enters on the bill the number of claimable Medicare patient days on the cost report. (Medicare patient days always refer to cost report days.) For PPS facilities the FI counts, for the cost report, utilization and Pricer purposes, all days for which Part A payment may be made to the hospital. This includes days for which the provider is not liable under the limitation of liability provision. It does not count days for which no Part A payment may be made for cost report, utilization or Pricer purposes.

For non-PPS providers, the FI does not count the days for Pricer purposes, because DRG payment or outlier calculations are not made.

B. Medically Unnecessary Days for Which the Provider May Charge the Beneficiary

Days on which the hospital furnished no covered Part A services are not charged to utilization and are not counted as Medicare patient days.

If the hospital or SNF stay includes any medically unnecessary days for which the provider has met the requirements of §§40.2.2 C or D for charging the beneficiary, the FI counts those days as noncovered under Part A for cost report, utilization and Pricer purposes.

Since the provider may not be aware of the date benefits are exhausted or when the outlier threshold is reached, the FI verifies the provider's counts. If, for any reason, the FI or the QIO determines fewer days are claimable (e.g., if the FI or the QIO indicates that benefits are exhausted), the FI will adjust cost report days for its PS&R system. If the FI or the QIO determines fewer days are claimable for the cost report, it determines the proper number of days of utilization to charge the beneficiary and the proper number of days for the length of stay used by Pricer. It uses the factors in §40.1 and §40.1G to make these calculations.

C. Medically Unnecessary Outlier Costs for Which the Hospital May Not Charge

If the hospital requests payment for cost outlier, and the Medicare covered charges converted to cost exceed the cost outlier threshold, the services which are not reasonable and necessary (or constitute custodial care) which are noncovered, but for which the hospital may not charge the beneficiary are determined as follows:

- The hospital determines the lesser of the following:
    - The cost of the medically unnecessary services (converting the charges for the medically unnecessary services to cost); or
    - The amount by which the adjusted cost of the stay exceeds the cost outlier threshold.

Ancillary services, which are not required to be furnished on an inpatient basis, are treated as medically unnecessary, but nevertheless may be covered under Part B.

- If the costs in excess of the outlier threshold exceed the cost of the medically unnecessary services, the cost of all of the medically unnecessary services are treated as noncovered costs. If these costs exceed the costs in excess of the cost outlier threshold, beginning with the cost of the last medically unnecessary service in the stay, the hospital must identify, and add on, in reverse order, the cost of other medically unnecessary services until the total cost of medically unnecessary services reaches the costs in excess of the cost outlier threshold. If the cost of the last service to be added on in this manner brings the cost of medically unnecessary services over the amount of costs in excess of the cost outlier threshold, only the portion of the cost of that last medically unnecessary service (in the order of the addition) needed to bring the total of the medically unnecessary costs up to the costs in excess of the cost outlier threshold is added on. In this case, the costs in excess of the cost outlier threshold are treated as the noncovered costs.

- Once the costs of medically unnecessary services to be treated as noncovered are determined, convert them to charges for each applicable service/revenue category, e.g., accommodations, radiology, pharmacy, by dividing the costs treated as not medically necessary in each category by 72 percent. The medically unnecessary

charges determined are treated as noncovered charges. Days for which all costs are found to be noncovered are treated as noncovered days.

- The hospital determines which medically unnecessary services and days treated as noncovered are services and days for which the beneficiary can be charged under §40.2.2C or E. The remainder of the services and days are the medically unnecessary services and days treated as noncovered even though the hospital may not charge the beneficiary. However, the distinction between medically unnecessary services and days for which the hospital may charge, and those for which it may not, will not be reflected in the charges shown on the inpatient hospital billing. Both are combined and shown as noncovered services and days.

The determination of medically unnecessary cost outliers is not affected by non-entitlement days or days after benefits are exhausted. If the stay is covered or treated as covered, the beneficiary is treated as entitled to Part A, and as having benefits available throughout the stay.

40.2.1 - Noncovered Admission Followed by Covered Level of Care

(Rev. 1, 10-01-03)
HO-415.16, A3-3610.12

Where a beneficiary receives noncovered care at admission, and is notified as such, but subsequently is furnished covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. This is applicable to PPS and non-PPS billings.

The following billing entries identify this situation:

- Admission date (not the deemed date) in FLs 6 and 17.

- Occurrence code "31" and the date the hospital provided notice to the beneficiary are in FLs 32 - 35.

- Occurrence span code 76 indicates the noncovered span from admission date through the day before covered care started.

- Value code 31 in FLs 39 - 41 is used to indicate the amount which was charged the beneficiary for noncovered services.

- Noncovered charges related to the noncovered services.

- The principal diagnosis is shown as the diagnosis that caused the covered level of care.

- Only procedures performed during the covered level of care are shown on the bill.

If a no payment bill for the noncovered level of care has been processed, the hospital prepares and forwards a new initial bill.

40.2.2 - Charges to Beneficiaries for Part A Services

(Rev. 1495; Issued: 05-02-08; Effective Date: 10-01-08; Implementation Date: 10-06-08)

The hospital submits a bill even where the patient is responsible for a deductible which covers the entire amount of the charges for non-PPS hospitals, or in PPS hospitals, where the DRG payment amount will be less than the deductible.

A hospital receiving payment for a covered hospital stay (or PPS hospital that includes at least one covered day, or one treated as covered under guarantee of payment or limitation on liability) may charge the beneficiary, or other person, for items and services furnished during the stay only as described in subsections A through H. If limitation of liability applies, a beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 of this manual. For related notices for inpatient hospitals, see CMS Transmittal 594, Change Request3903, dated June 24, 2005.

A. Deductible and Coinsurance

The hospital may charge the beneficiary or other person for applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. The FI deducts the deductible and coinsurance first from the PPS payment. Where the deductible exceeds the PPS amount, the excess will be applied to a subsequent payment to the hospital. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

B. Blood Deductible

The Part A blood deductible provision applies to whole blood and red blood cells, and reporting of the number of pints is applicable to both PPS and non-PPS hospitals. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.) Hospitals shall report charges for red blood cells using revenue code 381, and charges for whole blood using revenue code 382.

C. Inpatient Care No Longer Required

The hospital may charge for services that are not reasonable and necessary or that constitute custodial care. Notification may be required under limitation of liability. See CMS Transmittal 594, Change Request3903, dated June 24, 2005, section V. of the attachment, for specific notification requirements. Note this transmittal will be placed in Chapter 30 of this manual at a future point. Chapter 1, section 150 of this manual also contains related billing information in addition to that provided below.

In general, after proper notification has occurred, and assuming an expedited decision is received from a Quality Improvement Organization (QIO), the following entries are required on the bill the hospital prepares:

- Occurrence code 3l (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;

- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and

- Value code 3l (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D. Change in the Beneficiary's Condition

If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the QIO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after the beneficiary again required inpatient hospital care until proper notification occurs (see subsection C).

If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with another notice when the patient chose not to be discharged to the SNF bed.

E. Admission Denied

If the entire hospital admission is determined to be not reasonable or necessary, limitation of liability may apply. See 2005 CMS transmittal 594, section V. of the attachment, for specific notification requirements.

NOTE: This transmittal will be placed in Chapter 30 of this manual at a future point.

In such cases the following entries are required on the bill:

- Occurrence code 3l (and date) to indicate the date the hospital notified the beneficiary.

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.

- Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.

- Value code 3l (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization that was not necessary or reasonable. They are included as noncovered charges on the bill.

F. Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary

If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires inpatient hospital care) the hospital may charge the beneficiary or other person for the services or care according the procedures given in CMS Transmittal 594, Change Request3903, dated June 24, 2005.

The following bill entries apply to these circumstances:

- Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.

- Value code 3l (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G. Nonentitlement Days and Days after Benefits Exhausted

If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). It may charge the beneficiary for the lesser of:

- The number of days on which the patient was not entitled to benefits or after the benefits were exhausted; or

- The number of outlier days. (Day outliers were discontinued at the end of FY 1997.)

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits, or after benefits were exhausted, the hospital may charge for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of

discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until the number of days counted off equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H. Contractual Exclusions

In addition to receiving the basic prospective payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, non-entitlement to Part A, or exhaustion of benefits. For example, it may charge for most cosmetic and dental surgery.

I. Private Room Care

Payment for medically necessary private room care is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See the Medicare Benefit Policy Manual, Chapter 1.) When the beneficiary accepts the liability, the hospital will supply the service, and bill the beneficiary directly. If the beneficiary believes the private room was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

J. Deluxe Item or Service

Where a beneficiary requests a deluxe item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition, the hospital may collect the additional charge if it informs the beneficiary of the additional charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested. If the beneficiary believes that the more expensive item or service was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

K – Inpatient Acute Care Hospital Admission Followed By a Death or Discharge Prior To Room Assignment

A patient of an acute care hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of their own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07 which indicates they left against medical advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

40.2.3 - Determining Covered and Noncovered Charges - Pricer and PS&R

(Rev. 1, 10-01-03)

Accommodation charges for days covered by Medicare are covered charges. Ancillary charges incurred on these days are also covered charges as long as these services are covered under Medicare. The FI enters them into its PS&R unless it or the QIO denies them as exclusions from coverage or as medically unnecessary. For PPS hospitals, the FI counts these charges for Pricer unless the charges are included as pass-through costs.

The FI does not count for Pricer or the PS&R:

- Charges the provider has shown as noncovered. (If the provider has complied with the notice requirements in Chapter 30, it may bill the beneficiary.);
- Services on noncovered days;
- Charges for personal comfort and/or convenience items;
- Accommodations and routine charges for the day of discharge, death, or beginning of a leave of absence, unless it is also the day of admission; and
- Charges for ancillary services on the day of discharge, death, or beginning of a leave of absence if the preceding day is noncovered under §40.2.B.

MSP Issues

The FI resolves any MSP issues not handled by §40.1.G using the instructions in the Medicare Secondary Payer Manual specific for reasonable cost providers and the instructions in specifically for PPS providers.

G. Determining Covered and Noncovered Charges - Part B

The FI counts as covered under Part B, for cost report and deductible purposes, the charges for which Part B payment may be made, except as follows:

- It counts as covered for deductible, but not cost report purposes, those charges for which the provider is liable for technical reasons; and
- It does not count charges for which the provider is liable because services are not medically necessary for either deductible or cost report purposes.

40.2.4 – IPPS Transfers Between Hospitals

(Rev. 87, 02-06-04)
A3-3610.5, HO-415.8

A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another 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 Hospitals

Payment is made to the final discharging hospital at the full prospective payment rate. Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls and multiplied by the patient's length of stay at the transferring hospital). If less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate. 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.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage indexes 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 DRG different than the DRG in the transferring hospital, payment to each is based upon the DRG under which the patient was treated. Day outlier payments are payable based upon the admission and discharge dates. For transfers on or after, October 1, 1984, the transferring hospital may be paid a cost outlier payment but may not be paid a day outlier payment (Day outliers were discontinued at the end of FY 1997).

An exception to this policy applies to DRGs 385 and 456. The weighting factors for these assume that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into one of these DRGs 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 Hospital to Hospitals or Units Excluded from 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 prospective payment (IRF or LTCH). (See exceptions in paragraph C of this section).

A per diem payment is made to the transferring hospital when patients are transferred to a Maryland hospital or to a New York Finger Lakes hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program. Also, a per diem 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.

C – IPPS Transfers – 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 diagnosis-related groups (DRGs) listed 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). Some facilities excluded from IPPS are inpatient rehabilitation facilities and units, long term care hospitals, psychiatric hospitals and units, children's hospitals, and cancer hospitals.

To a skilled nursing facility.

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.

D - Qualifying DRGs

The original qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

Effective October 1, 2003, DRGs 263 and 264 are deleted from the postacute care transfer policy.

Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.

40.2.5 - Repeat Admissions

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

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 may 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.

40.2.6 - Leave of Absence
(Rev. 1, 10-01-03)

HO-400.C

Providers submit one bill for covered days and days of leave when the patient is ultimately discharged.

The provider bills for covered days with days of leave included in FL 8, Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by their FI on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

Where a patient on leave of absence from a non-PPS hospital who was shown as "Still Patient" (patient status code 30, FL 22) on an interim bill:

- Has not returned within 60 days, including the day leave began, or
- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

40.3 - Outpatient Services Treated as Inpatient Services
(Rev. 1429; Issued: 02-01-08; Effective: 07-01-08; Implementation: 07-07-08)

A3-3610.3, HO-415.6, HO-400D, A-03-008, A-03-013, A-03-054

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.

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

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 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 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 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)

Nondiagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity 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 patient'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 patient 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.

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

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, CWF will reject therapeutic 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.

40.3.1 - Billing Procedures to Avoid Duplicate Payments

(Rev. 1, 10-01-03)

HO-400H

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the DRG for a related inpatient admission in the facility or in another hospital.

Where the hospital bills separately for nonphysician services provided to a patient either on the day before admission to a PPS hospital or during a patient's inpatient stay, the claim will be rejected by the FI as a duplicate and the hospital may be subject to sanction penalties per §1128A of the Act.

50 - Adjustment Bills

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of A/B MACs or the FIs medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be initiated as a result of OIG and MSP requests. The FI will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill for Payer A, B, or C.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25.

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment bill to CWF following it's acceptance of the initial bill. To verify CMS' acceptance, it take ones or both of the following actions:

A. General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- intermediary control number (ICN/DCN);
- Surname;
- HICN;

When a definite match cannot be made on the 3 fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;

- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and

- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect HICNs. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	FI
XXM	MSP
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the FI will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the FI receives a CWF alert or an CMS-L1002.

The FI prepares an adjustment if instructed by CO or RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for

a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the FI must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.

If the FI does not service the provider, CMS will contact the FIs, which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an FI of the appropriate adjustment actions.)

B. Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice for adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date through the discharge date. When the adjustment bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

50.1 - Tolerance Guidelines for Submitting Adjustment Requests
(Rev. 1, 10-01-03)

A3-3664.1.A

When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the Form CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/non-covered days;
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing provider;
- Discharge status in a PPS hospital;
- Diagnosis or Procedures that impact the assigned DRG code; or
- Outlier payment amount.

The provider submits most adjustment requests as debits, using bill type XX8.

Also, it submits a debit-only adjustment request to the FI if the hospital previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The FI then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to CMS, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

50.2 - Claim Change Reasons
(Rev. 1, 10-01-03)

HO-411.2, HO-IM411.2, HH-445

A. Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a HICN or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450. For electronic CMS-1450, enter the claim change reason code as a condition code on record type 41 in fields 4-13. For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B. Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The FI must apply them to each incoming adjustment request.

- If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."

- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."

- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the FI rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the FI rejects the request back to the provider with the following message, "only one claim change reason code may apply to a single adjustment request from a provider. Choose the single claim change reason code that best describes the reason for the provider's request and resubmit."

- If the provider submits an adjustment request as type of bill not equal to XX7 or XX8, the FI rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to XX7 or XX8."

- If the claim change reason code is equal to D0, the FI compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."

- If the claim change reason code is equal to D1, the FI compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the FI rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."

- If the claim change reason code is equal to D2, the FI compares revenue codes/HCPCS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS must change for claim change reason code D2."

- If the claim change reason code is equal to D3, the FI compares the ending date on the provider's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Thru dates must change for the claim change reason code D3."

- If the claim change reason code is equal to D4, the FI compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."

- If the claim change reason code is equal to D5 or D6, type of bill must be equal to XX8 on the provider's request. If type of bill is not equal to XX8, the FI rejects the request back to the provider with the message, "Type of bill must be equal to XX8 for claim change reason codes D5 or D6."

- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the FI rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."

- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the FI rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the FI rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."

- If the claim change reason code is equal to E0, the FI compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the FI rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

If an adjustment the provider initiates results in a change to a higher weighted DRG, the FI edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the FI processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the FI processes the claim for payment and forwards it to CWF.

The FI must suspend for investigation all adjustment requests with claim change reason codes D4, D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

C. Additional edits

The FI must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;
- A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;
- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for a PPS provider. The FI must investigate if the change is from patient status 02, transferred to another acute care facility.

50.3 - Late Charges
(Rev. 1, 10-01-03)

HO-411.3, HO-IM411.3

Providers billing under Inpatient Hospital PPS, Outpatient PPS, SNF PPS, or HHA PPS may not bill late charges, nor will the contractor accept such bills, for any type of PPS service, inpatient or outpatient. Charges omitted from the original bill must be submitted on an adjustment bill that contains all pertinent charges including those billed earlier. When the provider submits late charges on bills to the FI as bill type XX5, these bills contain **only** additional charges. Adjustment requests and not late charge bills should be submitted for

- Services on the same day as outpatient surgery subject to the ASC limit,
- ESRD services paid under the composite rate,

- All inpatient accommodation charges, and

- All inpatient PPS ancillaries as adjustment requests.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for HHA services under either Part A or Part B, hospice services, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CHMC services, and ESRD services not included in the composite rate; and

- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS hospitals. The hospital may **not** submit late charges (XX5) for inpatient accommodations. The hospital must submit these as adjustments (bill type XX7).

The FI has the capability to accept XX5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any XX5 type bills received:

- Pass all initial bill edits, including duplicate checks.

- Must not be for any of: Inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an XX7 debit-only or XX8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate."

- When an XX5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, HICNs equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.

- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (XX1)."

- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:

- For all providers (any bill type), if any are the same, and are revenue codes 041x, 042x, 043x, 044x, 063x, 076x, or 091x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For HHAs (bill type 32X, 33X, or 34X), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0291, 0293, 055x, 056x, 057x, 058x, 059x, 060x, 066x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For hospital outpatient services (bill type 13X only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0255, 032x, 033x, 034x, 035x, 040x, 062x, 073x, 074x, 092x, or 0943, the FI rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For RDFs (bill type 72X or 73X), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 0634, 0635, 082x, 083x, 084x, 085x, or 088x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (XX7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.

- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any XX5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

60 - Swing-Bed Services

(Rev. 1105, Issued: 11-09-06, Effective: N/A, Implementation: 12-11-06)

Swing-bed services must be billed separately from inpatient hospital services. Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their

NPI. NOTE: The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.):

- "U" = short-term/acute care hospital swing-bed;
- "W" = long-term hospital swing-bed; and
- "Y" = rehabilitation hospital swing-bed.

A. Inpatient Hospital Services in a Swing-Bed

The patient status code of 03 is inserted on the claim in FL 22 when the beneficiary swings from acute to SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The FI indicates in FL 6 the last day of care at the hospital level.

If the beneficiary is discharged from a Medicare swing bed and remains in the hospital, there is no need for a no-pay bill. However, if a beneficiary continues to receive care after completing their stay in a SNF swing bed, in a NF swing bed, the hospital must submit covered claims to Medicare.

B. SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;

- State level agreements may call for varying types of bill coding in FL 4. CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the FI accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, i.e., 18X or 21X. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown.

70 - All-Inclusive Rate Providers

(Rev. 1, 10-01-03)
A3-3660.4

70.1 - Providers Using All-Inclusive Rates for Inpatient Part A Charges

(Rev. 1, 10-01-03)

A3-3660.4

Some providers have been approved to bill a flat fee charge for inpatient services based on either a daily basis or total stay basis for services furnished. This is an "All-Inclusive Rate." These charges may cover room and board, including ancillary services, or room

and board only. These instructions explain the essential data entries that must be made on the Form CMS-1450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate;
- One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate;
- One all-inclusive charge rate for accommodations and another for ancillary services, including the cost of blood in the all-inclusive rate; or
- One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing FLs 42-48 of the billing form.

A. Accommodations

Revenue Codes - Codes that identify the accommodations furnished, ancillary services provided or billing calculation are entered in FL 42. The code indicates whether the rate includes charges for ancillary services or only room and board.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.

Where the all-inclusive rate varies with the type of accommodation, FL 84 (Remarks) is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantitative measure for services furnished, by revenue category, to or for the patient which includes items such as the number of accommodation days, pints of blood, or renal dialysis treatments, is entered in FL 46.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is entered in FL 47.

Noncovered Charges - The total non-covered charges pertaining to the related revenue code for the current billing period is entered in FL 48.

B. Ancillary Services

One All-Inclusive Charge Rate - Hospitals with one all-inclusive charge rate, including ancillary services, are reflected in the revenue code in FL 42. The total charge in FL 47 reflects the charge for both accommodations and ancillary services.

Separate Ancillary All-Inclusive Rate - Some providers segregate charges for ancillary services for billing purposes. Where a separate flat rate charge for ancillary services is incurred either on a daily or total stay basis, the provider enters separate codes in FLs 42-46 for the services. These codes indicate whether the total charge includes only ancillary cost or includes other costs (i.e., blood).

If applicable, the following additional billing instructions are applied:

- Blood

  Whenever whole blood is furnished the patient, FLs 39-41 are completed. If the all-inclusive rate does not include the charge for whole blood or packed cells, FL 42-46 are completed in the same way a provider not using all-inclusive rates would complete them. When the provider discounts its customary charges for unreplaced blood to which the deductible is applicable, it shows the charges before the discount.

  If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint is entered in FLs 39-41. No amount can be shown in the Total Charges column since the rate includes the cost of blood. It is not necessary to show the cost for any replaced blood.

- All-Inclusive Charges According to Disease, Injury, or Type of Treatment

  Providers that have a charge system based on the patient's illness or injury or type of treatment complete the line(s) for type of accommodation furnished showing number of days, rate, and total charges. The rate amount and total amounts must be the same. Blood entries are indicated as above.

- Physician's Component

  As with providers having a schedule of charges for individual services, the amount of any physician's component included in the all-inclusive charge is removed from the total covered charges before applying the inpatient deductible or coinsurance.
- Combined Billing

  CMS does not encourage the all-inclusive rate provider to combine bill. However, if it does, it must develop the capability and indicate in FL 84, Remarks, the number and type of each service it is combined billing. To identify such cases, the remark "Combined Billing" must be written in FL 84, Remarks.
  NOTE: Combined billing was eliminated with Outpatient PPS.

80 - Hospitals That Do Not Charge
(Rev. 1, 10-01-03)

A3-3660.5

Participating hospitals that do not charge individuals and also meet the exceptions to the law that normally exclude payment for expenses paid for directly or indirectly by a governmental entity, may be reimbursed the reasonable cost of furnishing covered services to Medicare beneficiaries. The following special procedures apply to their bills.

- Part A Services

Computing Medicare Billing Rate

The Medicare billing rate per day is determined by the following equation:

Total allowable inpatient cost = cost per day per patient

Total inpatient days

Thus, the billing rate that appears is the average inpatient cost per day per inpatient as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the FI determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

Computing Medicare Billing Rate (Inpatient)

The Medicare billing rate is determined in the following manner:

Total available inpatient cost = Cost per day per patient

Total inpatient days

The FI multiplies the cost per day per patient by 93 percent for short-term hospitals and by 98 percent for long-term hospitals. (See §2208.lE of the Provider Reimbursement Manual, Part I, for definitions of "short-term" and "long-term" hospitals.) Then it applies the following fixed percentages. The result is the Medicare billing rate.

Computing Medicare Billing Rate (Outpatient)

The Medicare billing rate is determined by the following equation:

Total allowable outpatient cost = average cost per visit

Total visits (occasions of service)

Thus, the billing rate is the average cost per outpatient visit as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the FI determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

80.1 - Medicare Summary Notice (MSN) for Services in Hospitals That Do Not Charge

(Rev. 1, 10-01-03)

A3-3660.5.A

Where the hospital does not charge for outpatient services, the FI does not send the individual an MSN. This avoids confusion and the appearance that the beneficiary is liable for services received.

90 - Billing Transplant Services

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Medicare covers the following organ transplants: kidney, heart, lung, heart/lung, liver, pancreas, pancreas/kidney, and intestinal/multi-visceral. Medicare also covers stem cell transplants for certain conditions.

On March 30, 2007, the Department of Health and Human Services (DHHS) established a regulation authorizing the survey and certification of organ transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the Federal agency responsible for monitoring compliance with the Medicare conditions of participation. All hospital transplant programs covered by the regulation (does not include stem cell transplants), whether currently approved by CMS or seeking initial approval, must submit a request for approval under the new regulations to CMS by December 26, 2007 (180 days from the effective date of the regulation.)

http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

Transplant hospitals should review the above Web site and send applications to the following address:

Centers for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

The A/B MACs or the FI may choose to review claims if data analysis deems it a priority.

90.1 - Kidney Transplant - General
(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A3-3612, HO-E414

A major treatment for patients with ESRD is kidney transplantation. This involves removing a kidney, usually from a living relative of the patient or from an unrelated person who has died, and surgically placing the kidney into the patient. After the beneficiary receives a kidney transplant, Medicare pays the transplant hospital for the transplant and appropriate standard acquisition charges. Special provisions apply to payment. For the list of approved Medicare certified transplant facilities, refer to the following Web site:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

A transplant hospital may acquire cadaver kidneys by:

- Excising kidneys from cadavers in its own hospital; and

- Arrangements with a freestanding organ procurement organization (OPO) that provides cadaver kidneys to any transplant hospital or by a hospital based OPO.

A transplant hospital that is also a certified organ procurement organization may acquire cadaver kidneys by:

- Having its organ procurement team excise kidneys from cadavers in other hospitals;

- Arrangements with participating community hospitals, whether they excise kidneys on a regular or irregular basis; and

- Arrangements with an organ procurement organization that services the transplant hospital as a member of a network.

When the transplant hospital also excises the cadaver kidney, the cost of the procedure is included in its kidney acquisition costs and is considered in arriving at its standard cadaver kidney acquisition charge. When the transplant hospital excises a kidney to provide another hospital, it may use its standard cadaver kidney acquisition charge or its standard detailed departmental charges to bill that hospital.

When the excising hospital is not a transplant hospital, it bills its customary charges for services used in excising the cadaver kidney to the transplant hospital or organ procurement agency.

If the transplanting hospital's organ procurement team excises the cadaver kidney at another hospital, the cost of operating such a team is included in the transplanting

hospital's kidney acquisition costs, along with the reasonable charges billed by the other hospital of its services.

90.1.1 - The Standard Kidney Acquisition Charge
(Rev. 1, 10-01-03)

A3-3612.1, A3-3612.3, HO-E417, HO-406, HO-E408, HO-E410, HO-E412, HO-E416, HO-E418, HO-E420

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and
- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on a separate line on the billing form.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

A. Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B. Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C. Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the FI at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE:

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

D. Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E. Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F. Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number).

G. Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

Applicable standard kidney acquisition charges are identified separately in FL 42 by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not** included in the prospective payment DRG 302 (kidney transplant). They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for procedure code 55.69 (kidney transplant). Where this procedure code is identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

90.2 - Heart Transplants

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A3-3613, HO-416

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

If a contractor has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of approved transplant centers, visit:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

A. Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987. All transplant hospitals will be recertified under the final rule, **Federal Register** / Vol. 72, No. 61 / Friday, March 30, 2007, / Rules and Regulations.

The CMS informs each hospital of its effective date in an approval letter.

B. Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C. Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. Charges for Heart Acquisition Services

The excising hospital bills the OPO, who in turn bills the transplant (implant) hospital for applicable services. It should not submit a bill to its contractor. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

E. Bill Review Procedures

The contractor takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1. Change in MCE Interface

The MCE creates a Limited Coverage edit for procedure code 37.51 (heart transplant). Where this procedure code is identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

2. Handling Heart Transplant Billings From Nonapproved Hospitals

Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

90.2.1 - Artificial Hearts and Related Devices

(Rev. 1592; Issued: 09-10-08; Effective Date: 05-01-08; Implementation Date: 12-01-08)

Effective for discharges before May 1, 2008, Medicare does not cover the use of artificial hearts, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to a "bridge to transplant").

Medicare does cover a Ventricular Assist Device (VAD). A VAD is used to assist a damaged or weakened heart in pumping blood. VADs are used as a bridge to a heart transplant, for support of blood circulation postcardiotomy or destination therapy. Refer to the NCD Manual, section 20.9 for coverage criteria.

The MCE creates a Limited Coverage edit for procedure code 37.66. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.

Effective for discharges on or after May 1, 2008, the use of artificial hearts will be covered by Medicare under Coverage with Evidence Development when beneficiaries are enrolled in a clinical study that meets all of the criteria listed in Pub. 100-03, Medicare NCD Manual, section 20.9.

90.3 - Stem Cell Transplantation

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used

to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

Bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. Effective October 1, 1990, these cases were assigned to MS-DRG 009, Bone Marrow Transplant.

The FI's Medicare Code Editor (MCE) will edit stem cell transplant procedure codes 4101, 4102, 4103, 4104, 4105, 4107, 4108, and 4109 against diagnosis codes to determine which cases meet specified coverage criteria. Cases with a diagnosis code for a covered condition will pass (as covered) the MCE noncovered procedure edit. When a stem cell transplant case is selected for review based on the random selection of beneficiaries, the QIO will review the case on a post-payment basis to assure proper coverage decisions.

Procedure code 41.00 (bone marrow transplant, not otherwise specified) will be classified as noncovered and the claim will be returned to the hospital for a more specific procedure code.

The A/B MACs or the FI may choose to review if data analysis deems it a priority.

90.3.1 - Allogeneic Stem Cell Transplantation
(Rev. 1, 10-01-03)

A3-3614.1, HO-416.2, A3-3614.2, HO-416.3

A. General

Allogeneic stem cell transplantation (ICD-9-CM Procedure Codes 41.02, 41.03, 41.05, and 41.08, CPT-4 Code 38240) is a procedure in which a portion of a healthy donor's stem cells are obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect. See the National Coverage Determinations Manual for more information.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

B. Covered Conditions

1. Effective for services performed on or after August 1, 1978:

- For the treatment of leukemia, leukemia in remission (ICD-9-CM codes 204.00 through 208.91), or aplastic anemia (ICD-9-CM codes 284.0 through 284.9) when it is reasonable and necessary; and

2. Effective for services performed on or after June 3, 1985:

- For the treatment of severe combined immunodeficiency disease (SCID) (ICD-9-CM code 279.2), and for the treatment of Wiskott - Aldrich syndrome (ICD-9-CM 279.12).

C. Noncovered Conditions

3. Effective for services performed on or after May 24, 1996:

- Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma (ICD-9-CM codes 203.00 and 203.01).

NOTE: Coverage for conditions other than these specifically designated as covered or noncovered in this section or National Coverage Determination Manual are left to individual FI's discretion.

90.3.2 - Autologous Stem Cell Transplantation (AuSCT)

(Rev. 526, Issued: 04-15-05, Effective: 03-15-05, Implementation: 05-16-05)

A. General

Autologous stem cell transplantation (AuSCT) (ICD-9-CM procedure code 41.01, 41.04, 41.07, and 41.09 and CPT-4 code 38241) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

B. Covered Conditions

1. Effective for services performed on or after April 28, 1989:

- Acute leukemia in remission (ICD-9-CM codes 204.01, lymphoid; 205.01, myeloid; 206.01, monocytic; 207.01, acute erythremia and erythroleukemia; and 208.01 unspecified cell type) patients who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched;

- Resistant non-Hodgkin's lymphomas (ICD-9-CM codes 200.00-200.08, 200.10-200.18, 200.20-200.28, 200.80-200.88, 202.00-202.08, 202.80-202.88,

and 202.90-202.98) or those presenting with poor prognostic features following an initial response;

- Recurrent or refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant); or

- Advanced Hodgkin's disease (ICD-9-CM codes 201.00-201.98) patients who have failed conventional therapy and have no HLA-matched donor.

2. Effective for services performed on or after October 1, 2000:

- Durie-Salmon Stage II or III that fit the following requirement: Newly diagnosed or responsive multiple myeloma (ICD-9-CM codes 203.00 and 238.6). This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse, and adequate cardiac, renal, pulmonary, and hepatic function.

3. Effective for services performed on or after March 15, 2005, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan (HDM), together with AuSCT, in treating Medicare beneficiaries of any age group with primary amyloid light-chain (AL) amyloidosis who meet the following criteria:

1. Amyloid deposition in 2 or fewer organs; and,

2. Cardiac left ventricular ejection fraction (EF) of 45% or greater.

C. Noncovered Conditions

Insufficient data exist to establish definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);

- Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);

- Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0-199.1);

- Multiple myeloma (ICD-9-CM code 203.00 and 238.6), through September 30, 2000.

- Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma (ICD-9-CM code 203.00 and 238.6)

- Non-primary (AL) amyloidosis (ICD-9-CM code 277.3), effective October 1, 2000; or

- Primary (AL) amyloidosis (ICD-9-CM code 277.3) for Medicare beneficiaries age 64 or older, effective October 1, 2000, through March 14, 2005.

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered is left to the FI's discretion.

90.3.3 - Billing for Stem Cell Transplantation

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

A. Billing for *Allogeneic Stem Cell Transplants*

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- *National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;*

- *Tissue typing of donor and recipient;*

- *Donor evaluation;*

- *Physician pre-admission/pre-procedure donor evaluation services;*

- *Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);*

- *Post-operative/post-procedure evaluation of donor; and*

- *Preparation and processing of stem cells.*

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stems cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see paragraph B of this section).

2. Billing for Acquisition Services

The hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above.

On the recipient's transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

B. Billing for *Autologous* Stem Cell Transplants

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in section A. above for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant. The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

90.4 - Liver Transplants
(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A. Background

For Medicare coverage purposes, liver transplants are considered medically reasonable and necessary for specified conditions when performed in facilities that meet specific criteria.

To review the current list of approved Liver Transplant Centers, see http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

90.4.1 - Standard Liver Acquisition Charge
(Rev. 1, 10-01-03)

A3-3615.1, A3-3615.3

Each transplant facility must develop a standard charge for acquiring a cadaver liver from costs it expects to incur in the acquisition of livers.

This standard charge is not a charge that represents the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with a liver acquisition.

Services associated with liver acquisition are billed from the organ procurement organization or, in some cases, the excising hospital to the transplant hospital. The excising hospital does not submit a billing form to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and the potential transplant donor. These charges are reflected in the transplant hospital's liver acquisition cost center and are used in determining the hospital's standard charge for acquiring a cadaver's liver. The standard charge is not a charge representing the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with liver acquisition. Also, it is an all-

inclusive charge for all services required in acquisition of a liver, e.g., tissue typing, transportation of organ, and surgeons' retrieval fees.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Form CMS-1450 or its electronic equivalent is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately in FL 42 by revenue code 0817 (Donor-Liver). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are **not** included in prospective payment DRG 480 (Liver Transplant). They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code 0817 in the HUIP record that it sends to CWF and the QIO.

A. Bill Review Procedures

The contractor takes the following actions to process liver transplant bills.

1. Operative Report

The contractor requires the operative report with all claims for liver transplants, or sends a development request to the hospital for each liver transplant with a diagnosis code for a covered condition.

2. MCE Interface

Code 50.51 (Auxiliary liver transplant) is always a non-covered procedure. However, the MCE contains a limited coverage edit for procedure code 50.59 (liver transplant). Where procedure code 50.59 is identified by the MCE, the contractor shall check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant, and the contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If yes, the claim is suspended for review of the operative report to determine whether the beneficiary has at least one of the covered conditions when the diagnosis code is for a covered condition. If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the contractor denies the claim.

NOTE: Some non-covered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. For example, primary biliary cirrhosis is a covered condition, secondary biliary cirrhosis is not a covered condition. Both primary and secondary biliary cirrhosis have the same **diagnosis** code ICD 9 571.6) Do not pay for noncovered conditions.

3. Grouper

If the bill shows a discharge date before March 8, 1990, the liver transplant procedure is not covered. If the discharge date is March 8, 1990 or later, the contractor processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigned CMS DRG 191 or 192. The contractor sent the bill to Pricer with review code 08. Pricer would then overlay CMS DRG 191 or 192 with CMS DRG 480 and the weights and thresholds for CMS DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns CMS DRG 480 and Pricer is able to price without using review code 08. If the discharge date is after September 30, 2007, Grouper assigns MS-DRG 005 or 006 (Liver transplant with MCC or Intestinal Transplant or Liver transplant without MCC, respectively) and Pricer is able to price without using review code 08.

4. Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The contractor will receive a copy of the letter.

90.5 - Pancreas Transplants Kidney Transplants

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A. Background

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant (ICD-9-CM procedure code 55.69). Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

B. Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD-9-CM procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The contractor must determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

Diabetes Diagnosis Codes

250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin

	dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

- Hypertensive Renal Diagnosis Codes:

403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure
585.1 - 585.6, 585.9	Chronic Renal Failure Code

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill 585.1 - 585.6, 585.9 on such a patient. In these cases one of the following V-codes should be present on the claim or in the beneficiary's history.

The provider uses the following V-codes only when a kidney transplant was performed before the pancreas transplant:

V42.0	Organ or tissue replaced by transplant kidney
V43.89	Organ tissue replaced by other means, kidney or pancreas

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the

hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a V-code.

C. Drugs

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D. Charges for Pancreas Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim.

E. Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor rejects the claim, using the following MSN:

- MSN 16.32, "Medicare does not pay separately for this service."

- Use the following Remittance Advice Message:

- Claim adjustment reason code B15, "Claim/service denied/reduced because this procedure or service is not paid separately."

- If a claim is denied because no evidence of a prior kidney transplant is presented, use the following MSN message:

- MSN 15.4, "The information provided does not support the need for this service or item."

The contractor uses the following Remittance Advice Message:

- Claim adjustment reason code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

To further clarify the situation, the contractor should also use new claim level remark code MA 126, "Pancreas transplant not covered unless kidney transplant performed."

90.5.1 – Pancreas Transplants Alone (PA)

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A. General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

B. Nationally Covered Indications

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

C. Billing and Claims Processing

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

Contractors who receive claims for PA services that were performed in an unapproved facility, should reject such claims. Contractors should use the following messages upon the reject or denial:

> Medicare Summary Notice MSN Message - MSN code 16.2 (This service cannot be paid when provided in this location/facility)
>
> Remittance Advice Message - Claim Adjustment Reason Code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service)

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

All-Inclusive List of Covered ICD-9 CM Diagnosis Codes for PA

(**NOTE: "**X" = 1 and 3 only)

250.0X	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

Procedure Codes

ICD-9 CM

52.80 - Transplant of pancreas

52.82 - Homotransplant of pancreas

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers 52.80 and 52.82 as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient. Contractors should use the following messages upon the reject or denial:

Medicare Summary Notice MSN Message - MSN code 15.4 (The information provided does not support the need for this service or item)

Remittance Advice Message - Claim Adjustment Reason Code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 1341, Issued: 09-21-07, Effective: 06-28-07, Implementation: 10-22-07)

A. Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

C. Billing

ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. The Medicare Code Editor (MCE) lists this code as a limited coverage procedure. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For this procedure where the provider is approved as transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date, the contractor must suspend the claim for clerical review of the operative report to determine whether the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition.

This review is not part of the contractor's medical review workload. Instead, the contractor should complete this review as part of its claims processing workload.

Charges for ICD-9-CM procedure code 46.97 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD-9-CM procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

There is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include, but are not limited to:

• Volvulus 560.2,

• Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,

• Volvulus gastroschisis 569.89, other specified disorders of intestine,

o Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,

o Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,

o Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,

o Inflammatory bowel disease 569.9, unspecified disorder of intestine,

o Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and

o Radiation enteritis 558.1.

D. Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. The Medicare Cost Report will include a separate line to account for these transplantation costs. For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim and use MSN message 21.6, "This item or service is not covered when performed, referred, or ordered by this provider;" 21.18, "This item or service is not covered when performed or ordered by this provider;" or, 16.2, "This service cannot be paid when provided in this location/facility;" and Remittance Advice Message,

Claim Adjustment Reason Code 52, "The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed."

100 - Billing Instructions for Specific Situations
(Rev. 1, 10-01-03)

100.1 - Billing for Abortion Services
(Rev. 1, 10-01-03)

A3-3652

Effective October 1, 1998**,** abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

A. "G" Modifier

The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998, and after. CWF will be able to recognize the modifier beginning July 1, 1999.

B. FI Billing Instructions

1. Hospital Inpatient Billing

Hospitals will bill the FI on Form CMS-1450 using bill type 11X. Medicare will pay only when condition code A7 or A8 is used in FLs 24-30 of UB92 along with an appropriate ICD-9-CM principal diagnosis code that will group to DRG 380 or with an appropriate ICD-9-CM principal diagnosis code and one of the four appropriate ICD-9-CM operating room procedure codes listed below that will group to DRG 381.

69.01 69.02 69.51 74.91

Providers must use ICD-9-CM codes 69.01 and 69.02 to describe exactly the procedure or service performed.

The FI must manually review claims with the above ICD-9-CM procedure codes to verify that all of the above conditions are met.

2. Outpatient Billing

Hospitals will bill the FI on Form CMS-1450 using bill type 13X, 83X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840	59851	59856
59841	59852	59857
59850	59855	59866

C. Common Working File (CWF) Edits

For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above ICD-9-CM procedure codes.

D. Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits Remittance Advice Message

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim is denied. The FI states on the MSN the following message:

> This service was denied because Medicare covers this service only under certain circumstances." (MSN Message 21.21).

For the remittance advice the FI uses existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code B5, "Claim/service denied/reduced because coverage guidelines were not met or were exceeded."

100.2 - Payment for CRNA or AA Services
(Rev. 1, 10-01-03)

A3-3660.9

Anesthesia services furnished on or after January 1, 1990, at a qualified rural hospital by a hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The FI determines the hospital's qualification using the following criteria.

The hospital must be located in a rural area (as defined for PPS purposes) to be considered. A rural hospital that qualified and was paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 could continue to be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it could establish before January 1, 1990, that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during 1989.

A rural hospital that was not paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 could be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it established before January 1, 1990, that:

- As of January 1, 1988, it employed or contracted with a CRNA or AA (but not more than one full-time equivalent CRNA or AA); and

- In both 1987 and 1989, it had a volume of 500 or fewer surgical procedures, including inpatient and outpatient procedures, requiring anesthesia services.

Each CRNA or AA employed by, or under contract with the hospital, must agree in writing not to bill on a fee schedule basis for services furnished at the hospital. A rural hospital can qualify and continue to be paid on a reasonable cost basis for qualified CRNA or AA services for a calendar year beyond 1990 if it could establish before January 1 of that year that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during the preceding year. For a calendar year beyond 1990, it must make its election after September 30, but before January 1. The FI determines the number of anesthetics by annualizing the number of surgical procedures for the 9-month period ending September 30.

A rural hospital that first elects reasonable cost payment for CRNA services for a calendar year after 1990 must demonstrate that:

- It had a volume of 500 or fewer surgical procedures, including inpatient and outpatient, requiring anesthesia services in the preceding year; and

- It meets the criteria that would have been met by a rural hospital first electing reasonable cost in calendar year 1990.

To prevent duplicate payments, the FI informs carriers of the names of CRNAs or AAs, the hospitals with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished prior to the hospital's election of reasonable cost payments, the carrier must recover the overpayment from the CRNA or AA.

100.3 - Resident and Interns Not Under Approved Teaching Programs
(Rev. 1, 10-01-03)

A3-3669

A. General

A provider's cost for the services furnished by residents and interns not under approved teaching programs (including physicians employed by the provider who are authorized to practice only in a provider setting) are covered under Part B. (Part A covers only the costs of services performed for inpatients by residents and interns who are under approved

teaching programs.) See the Medicare Benefit Policy Manual, Chapter 6 for further information on the coverage of these services.

The provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 096X, 097X, or 098X as applicable.

B. Provider Procedures

The cost of Part B residents' and interns' services to inpatients is calculated on a per diem basis by the hospital in consultation with its FI. The FI apportions the total cost of such services (including fringe benefits, etc.) between inpatient and outpatient services on the basis of the time spent on each. It obtains the inpatient per diem figure by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For the patients who are enrolled under Part B, regardless of whether Part A benefits are payable, the provider is reimbursed for 80 percent of the cost of providing these services. The provider collects or bills the complementary insurer for 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. The administrative cost of determining Part B deductible status involving the cost of query, response, recording, and accounting on an individual basis in the aggregate, exceeds the potential patient deductible obligation. Therefore, as long as the patient is entitled to Part A benefits no determination of the patient's deductible liability need to be made for inpatient Part B interns' and residents' services.

Patients not enrolled under Part B are liable for the entire cost of intern and resident services. The provider maintains a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of final cost settlement.

C. FI Procedures

Its FI assists the provider in arriving at the inpatient per diem rate for the cost of services covered under Part B provided by residents and interns. (See the Provider Reimbursement Manual, Part I, §2120 for apportioning costs between inpatient and outpatient per diem and §2406 for establishing interim rates.) The normal interim reimbursement rate applied to other provider services applies to Part B residents' and interns' services.

100.4 - Billing for Services After Termination of Provider Agreement
(Rev. 1, 10-01-03)

HO-404, HH-433

An agreement with a hospital is not time-limited and has no fixed expiration date.

A. Part A Billing

A hospital whose provider agreement terminates (voluntarily or involuntarily), may be reimbursed for covered Part A inpatient services for up to 30 days for services furnished **on or after the effective date of termination** for beneficiaries who were admitted **prior** to the termination date.

EXAMPLE:

Termination date: 6/30/01

Beneficiary admitted on or before 6/29/01

Payment can be made: 6/30/01, up to and including 7/29/01

B. Assuring That Hospitals Continue to Bill for Covered Services

Upon cessation of a hospital's participation in the program, it supplies the Regional Office the names and HICNs of Medicare beneficiaries entitled to have payment made on their behalf, and continues to bill for covered services in accordance with subsection A. It continues to submit "no-payment" death or discharge bills for Medicare beneficiaries admitted prior to the termination of the provider's agreement.

C. Part B Billing

Following termination of its agreement, a hospital is considered to be a "nonparticipating hospital." An inpatient of such a hospital who has Part B coverage, but for whom Part A benefits have been exhausted, or are otherwise not available, is entitled to reimbursement for those services that are covered in a nonparticipating institution. Services, if rendered, must be billed on Form CMS-1500 and sent to the Part B carrier. If a hospital has been billing on the CMS-1554 for physician services, it continues to do so.

If a terminated hospital meets the necessary criteria, it may be certified to provide emergency services, and will be assigned an emergency provider number (E suffix). This procedure is not automatic, however, and hospitals which are terminated for Life Safety Code violations may never be able to qualify as emergency providers. Should a terminated hospital later qualify as an emergency provider, billings are handled by the designated emergency FI.

100.4.1 - Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number

(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

Where a multiple-facility provider is assigned separate provider numbers for each component facility or where a provider is assigned a different number, it is required to use

the new number for all notices of admission, start of care notices, bills, etc., beginning with the date the new number is effective.

A. Inpatient

The component provider to which the new number is assigned must apportion costs for all patients who are inpatients in that component as of the first day of the next fiscal period when the new provider number goes in effect. The hospital must submit a discharge bill with the old provider number and an admission notice with the new. The date of discharge and the date of admission are the same date, which is the first day of the new fiscal period. All subsequent billings are submitted under the new provider number. If a no-payment situation where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit a discharge bill and admission notice. In this situation, only a final no-payment bill with a discharge date is submitted under the old provider number. Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished **before** the date of change in provider number, the hospital submits one corrected bill covering the entire period showing the old provider number. However, where services subsequently determined to be covered were furnished **after** the date of change, the hospital submits a corrected discharge bill with the old provider number and a new admission notice and billing with the new provider number.

Effective October 1, 2004, there are new rules pertaining to long term care hospitals. (See section 150.14.1).

B. Outpatient Services, Part B Ancillary Services and Home Health Agency Services

For outpatient services and Part B ancillary services, and home health agency services, the provider uses the old provider number for services provided up through the day before the effective date of the new provider number. Thereafter, it uses the new number when submitting bills.

100.5 - Review of Hospital Admissions of Patients Who Have Elected Hospice Care

(Rev. 1, 10-01-03)

HO-418

Review of admissions to inpatient general hospitals of beneficiaries who have elected hospice care assures that:

- Nonhospice Medicare coverage is provided to those beneficiaries only when the hospitalization was for a condition not related to the terminal illness, and

- When inpatient hospital services were provided as a hospice benefit, the services rendered were stipulated in the individual's plan of care as established by the hospice's interdisciplinary group.

A. Review for Nonrelated Hospital Admissions

To assure that nonhospice Medicare coverage is provided to beneficiaries who have elected hospice care only when hospitalization was for a condition not related to the terminal illness, the medical review agent reviews all inpatient hospital claims for these beneficiaries. Appropriate medical records will be requested and a determination made as to whether or not services were related to the individual's terminal illness.

Many illnesses may occur when an individual is terminally ill which are brought on by the patient's underlying condition. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of a weakened condition. Similarly, the setting of bones after fractures which occur in a bone cancer patient would be treatment of a related condition.

If the review reveals hospitalization to be unrelated to the individual's terminal illness, a determination as to the medical necessity and appropriateness of the admission is made. Payment will be totally denied or totally approved based on the finding. If, after review, the admission should have been totally denied, consideration under the limitation of liability provision (§1879 of the Act) applies.

If the review of medical records reveals hospitalization to be related to the individual's terminal illness, the claim is denied as services waived through the hospice election. Limitation on liability provision does not apply.

B. Review for Related Hospital Admissions

To assure that beneficiaries who have elected hospice care are receiving services as provided in the plans of care established by the hospice's interdisciplinary groups, the medical review agent reviews all inpatient hospital claims submitted by the hospice for these beneficiaries. Appropriate medical records (including the plans of care) are requested and a determination made as to whether or not services provided were related to the individual's terminal illness and stipulated in the plan of care.

If the review reveals that services provided were medically necessary and appropriate for the control of pain or acute or chronic symptom management as outlined in the individual's plan of care, the claim is approved.

If the review reveals that services provided to the hospice beneficiary were not stipulated in the plan of care as established by the hospice's interdisciplinary group, the claim is denied. Limitation on liability does not apply.

100.6 - Inpatient Renal Services

(Rev. 1, 10-01-03)

HO-E400

Section 405.1031 of Subpart J of Regulation 5 stipulates that only approved hospitals may bill for ESRD services. Hence, to allow hospitals to bill and be reimbursed for inpatient dialysis services furnished under arrangements, both facilities participating in the arrangement must meet the conditions of 405.2120 and 405.2160 of Subpart U of Regulation 5. In order for renal dialysis facilities to have a written arrangement with each other to provide inpatient dialysis care both facilities must meet the minimum utilization rate requirement, i.e., two dialysis stations with a performance capacity of at least four dialysis treatments per week.

Dialysis may be billed by an SNF as a service if: (a) it is provided by a hospital with which the facility has a transfer agreement in effect, and that hospital is approved to provide staff-assisted dialysis for the Medicare program; or (b) it is furnished directly by an SNF meeting all nonhospital maintenance dialysis facility requirements, including minimum utilization requirements. (See §§1861(h)(6), 1861(h)(7), title XVIII.)

100.7 – Lung Volume Reduction Surgery

(Rev. 768, Issued: 12-01-05; Effective: 11-17-05; Implementation: 03-02 06)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, "National Coverage Determinations".

The Medicare Code Editor (MCE) creates a Limited Coverage edit for procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.

The LVRS can only be performed in the facilities listed on the following Web site: www.cms.hhs.gov/coverage/lvrsfacility.pdf

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study was limited to 18 hospitals, and patients were randomized into two arms, either medical management and LVRS or medical management. The study was conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Hospital claims for patients in the NETT were identified by the presence of Condition Code EY. The JHU instructed hospitals of the correct billing procedures for billing claims under the NETT.

100.8 – Replaced Devices Offered Without Cost or With a Credit
(Rev. 1509, Issued: 05-16-08, Effective: 10-01-08, implementation: 10-06-08)

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, 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.

110 - Emergency and Foreign Hospital Services
(Rev. 1, 10-01-03)

110.1 - Services Rendered in Nonparticipating Providers
(Rev. 1677; Issued: 02-13-09; Effective/Implementation Date: 03-13-09)

A. Services in Nonparticipating Domestic Hospital

Payment may be made for certain Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. Items and services furnished in a domestic nonparticipating hospital may be reimbursed if the following apply:

- The hospital meets the definition of an emergency hospital. (See §110.3.)
- The services meet the definition of emergency services. (See §110.2.)
- The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §110.5.)

B. Beneficiary Services Outside United States

Items and services furnished outside the United States are excluded from coverage except for the following services, and certain services rendered on board a ship:

- Emergency inpatient hospital services where the emergency occurred:
    - While the beneficiary was physically present in the United States; or
    - In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another State.

See §110 for a description of claims processing procedures.

- Emergency or nonemergency inpatient hospital services furnished by a hospital located outside the United States, if the hospital was closer to, or substantially more accessible from, the beneficiary's United States residence than the nearest participating United States hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury (see §110 for a description of claims processing procedures);
- Physician and ambulance services furnished in connection with a covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the United States (see Chapter 1, General Billing Requirements, §10.1.4.1 of this manual for a description of claims processing procedures);

- Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry (see Chapter 1, General Billing Requirements, §10.1.4.7 for a description of claims processing procedures).

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while they were within the United States or purchased the item from an American firm.

Under the Railroad Retirement Act, payment is made to qualified railroad retirement beneficiaries (QRRBs) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements are met for the inpatient services; and

- Whether the physician and/or ambulance services were furnished in connection with the services.

Services for an individual who has elected Religious Nonmedical Health Care status may be covered if the above requirements are met but this revokes the Religious Nonmedical Health Care Institution election.

110.2 - Establishing an Emergency
(Rev. 1, 10-01-03)

A3-3698.1, HO-490.1

Claims for emergency services must be accompanied by a physician's statement describing the nature of the emergency and stating that the services were necessary to prevent the

death, or the serious impairment of, the beneficiary. A statement that an emergency existed is not sufficient. In addition, when inpatient services are involved, the statement must include the date when, in the physicians' judgment, the emergency ceased.

The finding of whether the patient's condition required emergency diagnosis or treatment is ordinarily based upon the physician's evaluation of the patient's condition immediately upon the beneficiary's arrival at the hospital.

However, the emergency nature of the situation may have been assessed by a physician who attended the patient where the incident resulting in hospitalization occurred (for example, a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the claim that emergency hospitalization was necessary.

Most emergencies are of relatively short duration so that only one bill is submitted. Generally, only one physician's statement is necessary. However, in the rare situation where an emergency continued over an extended period, subsequent requests for payment must be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A statement that the emergency continued to exist is not acceptable.

Additional information to support a finding that the services were emergency services from the physician, the hospital, and others (e.g., the police department at the scene of an accident) may be requested.

Medical necessity can be documented by the physician on a CMS-l77l, Attending Physician's Statement and Documentation of Medicare Emergency or by the beneficiary's medical records. The CMS-1771 can be obtained from:

Centers for Medicare & Medicaid Services
Forms Management Section
7500 Security Blvd.
Baltimore, MD 21244-1850

Or, the form can be downloaded from http://www.cms.hhs.gov/forms/

110.3 - Qualifications of an Emergency Services Hospital
(Rev. 1, 10-01-03)

A3-3698.2, HO-490.2

An emergency services hospital is a nonparticipating hospital that meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (A Federal hospital need not be licensed under State or local licensing laws to meet this definition.) In addition, the hospital must be primarily

engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type described in defining the term hospital.

The hospital must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. Psychiatric hospitals can qualify as emergency hospitals.

110.4 - Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation

(Rev. 1, 10-01-03)

A3-3698.3, HO-490.3

Services furnished by a laboratory that does not meet the hospital laboratory conditions of participation and is operated under a lease arrangement in a domestic emergency hospital are covered only if they are emergency inpatient services reimbursable under Part A.

A carrier may send an FI a claim from such a laboratory and identify it as an "Emergency Lead." The FI checks its files to see if a claim for emergency services was filed and, if so, determines whether the laboratory services were furnished during the period of emergency. If the emergency claim was forwarded to the appropriate FI for processing, it enters the date received on the laboratory claim.

If no emergency claim was filed, or laboratory services were not furnished in the period covered by the emergency claim, the FI develops the claim as a possible emergency. It includes the laboratory claim with any subsequent claim.

If no emergency is alleged, the FI records on the claim that no emergency existed and disallows it.

110.5 - Coverage Requirements for Emergency Hospital Services in Canada or Mexico

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

The following requirements must be met for payment to be made for emergency services received by Medicare beneficiaries in foreign hospitals:

- The hospital must meet the definition of an emergency hospital and be licensed or approved by the appropriate agency of the country in which it is located.

- The services meet the criteria of emergency services.

The foreign hospital must be closer to or substantially more accessible from the site of the emergency than the nearest U.S. hospital that was adequately equipped and available to treat the illness or injury.

1. Emergency Occurred in the U.S. (See §110.1.B for definition of the U.S.)

If the individual was physically present in the U.S. at the time the emergency occurred, the individual's reason for departure from the U.S. must have been specifically to obtain treatment at the foreign hospital. Services are not covered where the person's departure from the U.S. is part of a trip abroad and the foreign hospital is more accessible simply because the individual was in the process of travel. For example, the airplane on which the individual was traveling could not readily return to permit the person's removal.

2. Emergency Occurred in Canada

If the emergency occurred in Canada, the beneficiary must have been traveling, without unreasonable delay, by the most direct route between Alaska and another State. Benefits are not payable if the emergency occurred while a beneficiary was vacationing. The requirement of travel without unreasonable delay by the most direct route will be considered met if the emergency occurred while the beneficiary was enroute between Alaska and another State by the shortest practicable route, or while making a necessary stopover in connection with such travel.

NOTE: An emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

Ordinarily, the "shortest practicable route" is the one that results in the least amount of travel in Canada, consistent with the mode of travel used between the point of entry into Canada and the intended point of departure. The amount of travel in the U.S., prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel resulted in a saving of time or was necessary because of such factors as:

- Road or weather conditions;
- The age of the traveler;
- Health, or physical condition of the traveler;
- The need to make suitable travel arrangements; or
- The need to obtain acceptable accommodations.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching their destination (e.g., for the principal purpose of sightseeing or vacationing).

The term "necessary stopover" means a routine stopover for rest, food, or servicing of the vehicle, and a non-routine stopover (even though of significant duration) caused by such factors as unsuitable road or weather conditions, the age, health, or physical

condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.

110.6 - Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Coverage is provided for inpatient hospital services furnished in a foreign hospital that is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest available participating U.S. hospital that is adequately equipped to deal with the illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred.

"Residence" means the beneficiary's fixed and permanent home to which they intend to return whenever they are away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

The foreign hospital must meet accreditation requirements equivalent to JCAHO standards. For example, the Canadian Council on Hospital Accreditation (CCHA) has equivalent requirements. Thus, Canadian hospitals accredited by the CCHA meet the qualifying requirements. In the case of Mexican hospitals, the Dallas or San Francisco RO makes the determination, depending upon the hospital's location. Claims for services provided in countries other than Canada or Mexico should be sent to the carrier that is responsible for the state or territory where the emergency arose. In other words, the foreign claim would be processed similarly to how claims are processed in the state or territory where the emergency arose.

See §110.12.1 below for discussion of accessibility criteria.

Some claims for services furnished in a foreign hospital nearest to the beneficiary's U.S. residence will not be "emergency." In these nonemergency situations, it may be necessary to deny payment in whole or part, (even though it has been approved with regard to accessibility) because the services are not medically reasonable and necessary or involve custodial care (i.e., exclusions under §§1862(a)(1) and (9)).

Where a denial is made in a nonemergency foreign claim for reasons other than accessibility (e.g., cosmetic surgery benefits exhausted), the usual beneficiary denial notice procedures apply. However, in the case of denials under the medical necessity and custodial care exclusions, the FI applies the limitation on liability considerations under §1879 of the Act before issuing the denial notice.

The FI examines claims involving medical necessity or custodial care denials to determine if there is any evidence that the beneficiary (or the person acting on behalf of the beneficiary) was aware that the beneficiary did not require, or no longer required, a covered level of care. The foreign hospital, since it is not participating, is not under any obligation to furnish a written notice of noncoverage to a beneficiary in order to protect

itself from being held liable under the §1879 waiver of liability provision. However, there may be instances where the medical records of the denied foreign claim show that the beneficiary was advised that the beneficiary did not require, or no longer required, Medicare covered services, (e.g., written notice of noncoverage from the hospital's staff or a prior CMS denial notice). It will probably be rare where a finding is made that the beneficiary had knowledge of noncoverage, so that, generally, payments are made under the waiver of liability provision. The FI uses appropriate Medicare Summary Notice (MSN) and Remittance Advice denial messages for determinations involving the limitation on liability provision. See Chapter 21.

110.7 - Coverage of Physician and Ambulance Services Furnished Outside U.S.

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Physician and ambulance services which meet the coverage requirements of the Act and which are furnished in connection with inpatient services meeting the requirements of §§110.4 or 110.6 are covered under Part B. When these requirements are met, Part B payment is possible even though there may be no Part A payment because Part A benefits are exhausted or there is no Part A entitlement.

Where inpatient services in a foreign hospital are covered, payment will be made for:

- Physicians' services rendered to the beneficiary while an inpatient.

- Physicians' services rendered to the beneficiary outside the hospital on the day of admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized.

- Services of a foreign ship's physician who furnished emergency services in foreign waters on the day the beneficiary is admitted to a foreign hospital for a covered emergency stay.

- Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission. Return ambulance trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements in Medicare Benefit Policy Manual, chapter 10, and this manual, chapter 15 are applicable, unless the foreign hospitalization was covered as emergency services, then necessity and destination requirements are met.

The definition of "physician," for purposes of coverage of services furnished outside the U.S., includes a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services were furnished.

Only the beneficiary may file for Part B benefits. The assignment method may not be used. However, where the beneficiary is deceased, the rule for settling Part B underpayments is applicable, i.e., payment may be made to the foreign physician or ambulance company on the basis of an unpaid bill, provided the physician or ambulance company accepts the carrier's reasonable charge determination as the full charge.

The regular deductible and coinsurance requirements apply to physicians' and ambulance services.

110.8 - Claims for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Canadian Claims

Under the Railroad Retirement Act, payment is made by the RRB to Qualified Railroad Retirement Beneficiaries (QRRB) for covered hospital services furnished in Canadian hospitals as well as in the U.S. The Railroad Retirement Act does not cover physician and ambulance services; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements in §§110.1.B and 110.7 are met in regard to the inpatient services; and

- Whether the physician and/or ambulance services were furnished in connection with the services.

If either is not met, RRB denies the claim and notifies the beneficiary. If met, RRB refers the claim to the RRB carrier, PGBA, to determine if the coverage criteria for physician and/or ambulance services are met.

The hospital must forward all claims for services furnished QRRBs in Canada to:

Railroad Retirement Board
844 Rush Street
Chicago, IL 60611

If a QRRB is a resident of Canada, Medicare payments are reduced by the amount of payment made for the same services by the Canadian Provincial Health Insurance Plan.

B. Claims for services furnished in other foreign countries

The RRB does not pay for health care services furnished in foreign countries other than Canada. For services furnished to QRRB's in foreign countries other than Canada, see §110.1, §110.5, §110.6, §110.7, and §110.10.

110.9 - Nonemergency Part B Medical and Other Health Services
(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A Coverage

Nonemergency services to Medicare beneficiaries may be paid for if the coverage requirements for the services are met, and are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)

- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)

- Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic tests, or the provisions of x-ray or radium therapy.

- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.

- Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.

B Distinction Between Emergency and Nonemergency Medical and Other Health Services

Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to the hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals - blood is a biological - which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech-language pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services can be only under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, it may be made for diagnostic laboratory tests furnished by an emergency hospital only if the hospital meets the conditions of participation relating to hospital laboratories. It may be made only for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by it, only if it meets the conditions of participation relating to radiology departments.

C Claims Processing

The hospital enters the annotation "nonemergency-hospital accepts assignment" in Remarks of the Form CMS-1450. If it is determined that some or all of the services are not covered under the nonemergency provisions, the claim is returned to it (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

110.11 - Elections to Bill for Services Rendered Nonparticipating Hospitals

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Nonparticipating U.S. Hospitals

As a nonparticipating U.S. hospital meeting emergency requirements, the hospital has the option to bill the program during a calendar year by filing an election with its FI. If it files an election, it should submit claims for the following services furnished all Medicare beneficiaries throughout the year:

- Emergency inpatient services; and
- Emergency outpatient services.

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must agree to refund any monies incorrectly collected. It may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file a claim. The beneficiary may request information from the hospital or the FI as appropriate.

During November of each year, the FI will send the non-participating hospital a letter (see §120.3.1). Also, during November of each year, the FI will send a letter to each domestic hospital, giving it an opportunity to elect to bill Medicare if it has not been doing so (§120.3.2).

If during the year the hospital requests to bill the program, its FI will send the model letter in §120.3.3.

B. Billing for Services Furnished Prior to Certification

The following rules apply if a bill is submitted for services rendered before and after a hospital's certification (participation) date:

- PPS hospitals are paid the DRG, if the date of discharge is after the certification date.

- Other hospitals are paid for services rendered after the certification date. However, the hospital must include services before certification date on its cost report.

It should annotate in the upper right hand corner of the claim "Emergency Conversion."

C. Foreign Hospitals

Foreign hospitals may submit a statement to the appropriate FI stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When the FI is aware that a hospital is willing to bill the program for all covered services, it solicits the hospital's agreement to:

- Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);

- Not bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and

- Refund to the beneficiary any monies incorrectly collected.

A hospital may not file an election for a calendar year if it has charged any beneficiary for covered services during that year.

D. Submitting Claims

The beneficiary or the hospital that has elected to bill the program may submit emergency claims for payment to the appropriate FI for evaluation of accessibility or emergency factors.

The hospital completes the claim (Form CMS-1450 or electronic equivalent) according to billing instructions in Chapter 25. It enters "hospital filed emergency admission" in Item 94 "Remarks." It sends the completed bill and the necessary emergency documentation (Form CMS-1771, Attending Physicians Statement and Documentation of Medicare Emergency) or medical records to substantiate the emergency to the appropriate FI.

NOTE: See §120.2, "Designated FIs."

If the hospital submits a claim but has not filed an election to bill the program, it will be contacted to determine if it is qualified and wish to bill the program. If it declines, the claim will be denied. A claim will be solicited from the beneficiary.

If the hospital has filed a billing election and the beneficiary files a claim, the beneficiary's claim is denied and the hospital is contacted for the claim.

110.12 - Processing Claims

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

All claims are subject to development to determine whether the Medicare secondary payer provisions apply. (See Pub. 100-05, Medicare Secondary Payer Manual.)

A. Nonparticipating Hospitals

The processing FI is responsible for making accessibility and medical emergency determinations for physician and ambulance services.

1. Claims Subject to Technical Denials

The following claims are subject to technical denial:

- Foreign nonemergency services claims if:
    - The residence requirement is not met. (See §110.6.)
    - The hospital rendering the service does not meet JCAHO or equivalent accreditation requirements set by a hospital approval program of the country in which it is located.
    - The accessibility requirements are not met. (See §110.12.1.)
- Canadian travel claims when the requirements in §110.5 are not met.
- Emergency services claims for which the hospital does not meet the definition of an emergency hospital.
- Claims for which the query response shows the beneficiary is not entitled to benefits.
- Any foreign claim when Part A benefits are exhausted and Part B physician or ambulance claims are not involved.

2. Either the Accessibility or Medical Emergency Requirements are Not Met

Claim is denied but retained in case of appeal.

NOTE: Even though Part A or Part B emergency services furnished by U.S. hospitals are denied, Part B payment may be possible for Medical and Other Health Services specified in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6. Claim is retained in case of appeal.

3. Emergency Services Partially Denied

When the medical emergency is approved but not for the entire period, the claim is processed and payment made for the covered period.

B. Foreign Part B Physician and Ambulance Claims

The hospital must attach any Part B claim for foreign physician and ambulance services to the corresponding Part A claim and forward to the FI.

If the FI determines that the inpatient services were covered, it sends the physician and/or independent ambulance claim to the designated carrier for processing and payment. (See §110.7.)

If the Part A claim is denied on the basis of accessibility of medical emergency, the FI denies the Part B claim, and sends a denial letter to the claimant. It retains copies in case of appeal.

NOTE: Even though Part A benefits are totally or partially exhausted, payment may be made by the carrier for physician and independent ambulance services furnished if all coverage requirements are met.

If a Part A claim was partially denied because the emergency terminated, the FI makes a decision on the claim and any provider-based ambulance claim. It sends copies to the appropriate carrier for processing.

110.12.1 - Accessibility Criteria
(Rev. 1, 10-01-03)

A3-3698.13, HO-490.13

A. Emergency Claims

The FI uses the same criteria in domestic and foreign emergency claims. This includes services in a foreign religious non-medical health care institution and Canadian Travel claims. (See §110.5 and §110.9.)

Emergency determinations take into account such matters as relative distances of a participating hospital, and road conditions. The FI considers whether the nature of the emergency required immediate transportation to the nearest available hospital (i.e., the nonparticipating hospital) or, without hazard to the patient, would have permitted the additional transportation time to take the patient to a more distant participating hospital in the same general area.

The FI does not consider in its determination such factors involving selection of a hospital which reflect the personal preferences of the individual or physician, (e.g., physician does not have staff privileges at the participating hospital) nearness to beneficiary's residence, presence of previous medical records at the nonparticipating hospital, cost, or type of accommodations available.

The following sections discuss documentation of the accessibility requirement and provide guidelines for making a determination where the participating hospital is:

- Closer to the site of the emergency than is the admitting nonparticipating hospital;
- Fifteen or fewer miles farther from the site of the emergency than is the nonparticipating hospital; or
- Sixteen or more miles farther from the site of the emergency than is the admitting nonparticipating hospital.

In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it is presumed, in the absence of clear and convincing evidence to the contrary, that the services could have been provided in the participating hospital.

1. Participating Hospital Closer to Site of Emergency

If there is an adequately equipped participating hospital with available beds closer to the site of the emergency than the nonparticipating hospital, accessibility is not met. Claim is denied **unless** extenuating circumstances were present that necessitated admission to the nonparticipating hospital, e.g., because of road or traffic conditions additional travel time would have been needed.

2. Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

In this situation the accessibility is provisionally not met. The claim is reviewed to determine if the nature of the emergency required the immediate transportation to the nonparticipating hospital. If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient to the participating hospital without undue hazard, the accessibility requirement is not met. The claim is denied.

3. Participating Hospital More than 15 Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

The accessibility requirement is deemed met.

B. Foreign Nonemergency Claims

The following presumptions are applied to the relative accessibility of the nearest participating U.S. and foreign hospitals.

1. Admitting Foreign Hospital is Closer to the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is met.

2. Admitting Foreign Hospital is Farther From the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is not met unless evidence establishes the practical necessity for the beneficiary's admission. This requirement is met if the use of a closer participating U.S. hospital was impractical, e.g., non-availability of beds, needed equipment or personnel, or transportation not available.

In determining whether a foreign hospital is more accessible than a participating hospital, the FI does not consider the personal preference of the beneficiary, physician, or others in the selection of a hospital, the type of accommodations available, or the nonavailability of staff privileges to the attending physician.

C. Documenting Accessibility for Emergency Claims

The FI uses Form CMS-2628, Foreign HI Claim or Emergency Services Accessibility Documentation and Determination, to document accessibility in emergency claims. Access Form CMS-2628 from CMS at the following Web address: http://www.cms.hhs.gov/forms/

It checks the "met" block for claims that fall in the categories described in §§110.12.1A.2 or §110.12.1.A.3, and there are special circumstances of a nature not requiring medical judgment (e.g., Part I, Section C, Items 1, 2, and 5: bed unavailability, lack of transportation).

It checks the "not met" block for claims that fall in the category described in §110.12.A.1, **and** there are no special circumstances.
It checks the "not met-medical factors" for claims that fall in the category described in §110.12.A.1, **and** there are special circumstances requiring medical judgment (i.e., Part I, Section C, Items 4 and 6 unusual medical circumstances or nonavailability of needed equipment or personnel in the participating hospital).

110.12.2 - Medical Necessity
(Rev. 1, 10-01-03)
A3-3698.14, HO-490.14, A3-3698.15, HO-490.15

A. Emergency Services

Reimbursement for emergency inpatient hospital services is permitted only for those periods during which the patient's state of injury or disease is such that a health or life-endangering emergency existed and continued to exist, requiring immediate care that could be provided only in a hospital. The allegation that an emergency existed must be substantiated by sufficient medical information from the physician or hospital. If the physician's statement does not provide it, or is not supplemented by adequate clinical corroboration of this allegation, it does not constitute sufficient evidence.

Death of the patient does not **necessarily** establish the existence of a medical emergency, since in some chronic, terminal illnesses, time is available to plan admission to a participating hospital. The lack of adequate care at home or lack of transportation to a participating hospital does not constitute a reason for emergency hospital admission, without an immediate threat to the life and health of the patient. Since the existence of medical necessity for emergency services is based upon the physician's assessment of the patient prior to admission, serious medical conditions developing after a non-emergency admission are not "emergencies" under the emergency services provisions of the Act.

The emergency ceases when it becomes safe, from a medical standpoint, to move the individual to a participating hospital, another institution, or to discharge the individual.

B. Criteria

Since the decision that a medical emergency existed can be a matter of subjective medical judgment involving the entire gamut of disease and accident situations, it is impossible to provide arbitrary guidelines.

1. Diagnosis is Considered "Usually an Emergency"

An emergency condition is an unanticipated deterioration of a beneficiary's health which requires the immediate provision of inpatient hospital services because the patient's chances of survival, or regaining prior health status, depends upon the speed with which medical or surgical procedures are, or can be, applied. While many diagnoses (e.g., myocardial infarction, acute appendicitis) are normally considered emergencies, the hospital must check medical documentation for internal consistencies (e.g., signs and symptoms upon admission, notations concerning changes in a preexisting condition, results of diagnostic tests).

EXAMPLE: If the diagnosis is given as "coronary," the physician's statement is "coronary," without further explanatory remarks, and the statement of services rendered

gives no indication that an electrocardiogram was taken, or that the patient required intensive care, etc., further information is required. On the other hand, if the diagnosis is one that ordinarily indicates a medical and/or surgical emergency, and the treatment, diagnostic procedures, and period of hospitalization are consistent with the diagnosis, further documentation may be unnecessary. An example is: admitting diagnosis - appendicitis; discharge diagnosis - appendicitis; surgical procedures - appendectomy; period of inpatient stay - 7 days.

2. Patient Dies During Hospitalization

If an emergency existed at the time of admission and the patient subsequently expires, the claim is allowed for emergency services if the period of coverage is reasonable. However, death of the patient is not **prima facie** evidence that an emergency existed; e.g., death can occur as a result of elective surgery or in the case of a chronically ill patient who has a long terminal hospitalization. Such claims are denied.

3. Patient's Physician Does Not Have Staff Privileges at a Participating Hospital

The fact that the beneficiary's attending physician does not have staff privileges at a participating hospital has no bearing on the emergency services determination. If the lack of staff privileges in an accessible participating hospital is the governing factor in the decision to admit the beneficiary to an "emergency hospital," the claim is denied irrespective of the seriousness of the medical situation.

4. Beneficiary Chooses to be Admitted to a Nonparticipating Hospital

The claim is denied if the beneficiary chooses to be admitted to a non-participating hospital as a personal preference (e.g., participating hospital is on the other side of town) when a bed for the required service is available in an accessible, participating hospital.

5. Beneficiary Cannot be Cared for Adequately at Home

The patient who cannot be cared for adequately at home does not necessarily require emergency services. The claim is denied in the absence of an injury, the appearance of a disease or disorder, or an acute change in a pre-existing disease state which poses an immediate threat to the life or health of the individual and which necessitates the use of the most accessible hospital equipped to furnish emergency services.

6. Lack of Suitable Transportation to a Participating Hospital

Lack of transportation to a participating hospital does not, in and of itself, constitute a reason for emergency services. The availability of suitable transportation can be considered only when the beneficiary's medical condition contraindicates taking the time to arrange transportation to a participating hospital. The claim is denied if there is no immediate threat to the life or health of the individual, and time could have been taken to arrange transportation to a participating hospital.

7. "Emergency Condition" Develops Subsequent to a Non-emergency Admission to a Nonparticipating Hospital

Program payment cannot be made for emergency services furnished by a nonparticipating hospital when the emergency condition arises **after** a non-emergency admission. An example: treatment of postoperative complications following an elective surgical procedure or treatment of a myocardial infarction that occurred during a hospitalization for an elective surgical procedure. The existence of medical necessity for emergency services is based upon the physician's initial assessment of the apparent condition of the patient at the time of the patient's arrival at the hospital, i.e., prior to admission.

8. Additional "Emergency Condition" Develops Subsequent to an Emergency Admission to a Nonparticipating Hospital

If the patient enters a nonparticipating hospital under an emergency situation and subsequently has other injuries, diseases or disorders, or acute changes in preexisting disease conditions, related or unrelated to the condition for which the patient entered, which pose an immediate threat to life or health, emergency services coverage continues. Emergency services coverage ends when it becomes safe from a medical standpoint to move the patient to an available bed in a participating institution or to discharge the patient, whichever occurs first.

C. Documenting Medical Necessity

1. Physician's Supporting Statement

Claims for emergency services by a non-participating hospital should be accompanied by an Attending Physician's Statement and Documentation of Medicare Emergency, Form CMS-l77l or its equivalent. This form describes the nature of the emergency, furnishing relevant clinical information about the patient, and certifying that the services rendered were required as emergency services. However, a copy of the patient's hospital records may be submitted instead. It should include history, physical, and admission notes, the medical record admission sheet, nurses' notes, doctors' orders, discharge summary, and all progress notes. A statement that an emergency existed, or the listing of diagnoses, without supporting information, is not sufficient. In addition, the statement must include the date, in the physician's judgment, the emergency ceased. The physician who attended the patient at the hospital makes the statement concerning emergency services. Only in exceptional situations, with appropriate justification, may another physician having full knowledge of the case, make the certification.

2. Beneficiary's Statement in Canadian Travel Claims

In Canadian travel claims, the beneficiary's statement is considered in making a determination regarding medical necessity for emergency services; i.e., whether an

emergency occurred while a beneficiary was traveling between Alaska and another State by the most direct route without unreasonable delay. (See §110.5.)

110.12.3 - Time Limitation on Emergency and Foreign Claims
(Rev. 1, 10-01-03)

A3-3698.16, HO-490.16

The regular time limits apply to requests and claims for payment for emergency hospital services and hospital services outside the U.S., for physician and ambulance services furnished in connection with foreign hospitalization, and for nonemergency services furnished by a domestic nonparticipating hospital. See Chapter 1 for a description of these requirements.

A. Beneficiary Denial Notices

Denial messages on RAs and MSNs are sent to the nonparticipating hospital and/or beneficiary, as appropriate, whenever a domestic emergency or foreign claim is fully or partially denied.

B. Termination of Emergency Services

No payment will be made for inpatient or outpatient emergency services rendered after a reasonable period of medical care in relation to the emergency condition in question. Some services may be covered in a domestic nonparticipating hospital as Part B Medical and Other Health Services. (See the Medicare Benefit Policy Manual, Chapter 6.) If, based upon all information, the total period claimed for emergency services coverage does not exceed the time required for a reasonable period of emergency medical care, the entire inpatient stay is covered. The fact that a medical record or other information states that the patient showed definite improvement several days prior to discharge is not necessarily an indication that the need for emergency services ceased as of that date. The concept of a reasonable period of emergency medical care is most easily applied when relatively short-term medical care is followed by the patient's progressive improvement. There are situations or conditions in which the determination of the end of covered emergency services may be more difficult because the patient's impairment is prolonged, there is no progressive improvement, or the patient's course may be progressively downhill, even though the condition is not critical. The stroke patient may be in this category. In such cases the need for emergency medical care usually ceases before the need for medical care in an institutional setting (i.e., hospital or SNF) ceases. Thus, the reasonable period of emergency care does not include the entire hospital stay if the stay was prolonged beyond the point when major diagnostic evaluation and treatment were carried out.

The FI will make the determination based upon all information available. As a general rule, if the period claimed for emergency services exceeds by more than 3 to 5 days the date on which the record definitely indicates that there was substantial improvement in the patient's condition so that the patient could **possibly** have been moved to a participating

facility or discharged without damage to health, the period beyond the 3 to 5 days is denied. If the total period claimed for emergency services exceeds by no more than 3 to 5 days the date on which the record indicates substantial improvement in the patient's condition, the entire period is allowed.

This rule is intended to screen out short stay emergency hospitalization cases in which the patient was either discharged or transferred to a participating provider within a reasonable time after the medical record definitely indicated substantial improvement in the patient's condition.

The reasonable period of emergency care is that period required to provide relief of acute symptoms or for initial management of the condition while arrangements are made for definitive treatment. Two examples:

- Prostatic hypertrophy which results in acute urinary retention; and
- Mental illness with suicidal and/or homicidal tendencies.

In acute urinary retention, the reasonable period of emergency medical care includes the period required for catheterization and stabilization of the patient. The patient could then be transferred to a participating hospital for surgery or other required treatment. For the suicidal or homicidal patient, a reasonable period of emergency medical care includes the time required for initial management of the case while arrangements are made for transfer (by commitment or otherwise) to a participating hospital. A period of 24 to 48 hours of emergency care is usually sufficient in both cases.

110.13 - Appeals on Claims for Emergency and Foreign Services

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Part A

The FI will conduct reconsiderations on claims it processes and will notify the claimant of the decision. It will follow the guidelines in chapter 29. It will review the initial determination of the claim, including all documentation. It will prepare the necessary beneficiary notification and retain the file for 6 months after the month of the final determination. A reconsideration determination is a final and binding determination of the Secretary, unless it is reopened and revised, or unless a hearing revises an initial determination.

NOTE: The RRB conducts reconsiderations for hospital services under the Railroad Retirement Act for services rendered in Canada.

B. Part B

Where the FI or carrier receives a request for review of an initial determination, it conducts the review and sends the determination.

C. Appeal of Reconsideration

All Part B hearing requests on claims for physician and independent ambulance services furnished in a foreign country are within the jurisdiction of a carrier hearing officer regardless of who made the review determination. However, a hearing request on an FI determination is normally in connection with the Part A claim and considered and processed as such. If the enrollee had a Part A hearing and then requests a hearing on the same issue for the Part B claim, all pertinent information regarding the initial and reconsideration determinations and the hearing request are forwarded to the carrier. The beneficiary is notified of the transfer.

120 - Payment for Services Received in Nonparticipating Providers
(Rev. 1, 10-01-03)

A3-3699.1, HO-491

The Form CMS-1450 or its electronic equivalent must be used.

A. Hospital Filed Claims

1. Inpatient Services

The payment rate for inpatient claims is the lower of: 90 percent of the hospital's average inpatient per diem cost for all patients, or 85 percent of its regular charge for the services rendered. Its average per diem cost is determined from the most recent calculation of the average per diem cost by a non-Governmental third-party payer.

The cost of the services is adjusted by any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

Payment will be made to Federal hospitals that furnish emergency services, on an inpatient basis, to individuals entitled to hospital benefits. Payment will be based on the lower of the actual charges from the hospital or rates published for Federal hospitals in the "Federal Register" under **Office of Management and Budget - Cost of Hospital and Medical Care and Treatment Furnished by the United States; Certain Rates Regarding Recovery from Tortiously Liable Third Persons**.

Medicare will not pay Federal hospitals for emergency items or services furnished to veterans, retired military personnel or eligible dependents. However, Medicare can pay for the inpatient deductible charged by VA hospitals, or credit that amount to the Medicare Part A deductible, for emergency services furnished to veterans. If a Part A claim is denied, a denial notice will be forwarded to the beneficiary from the fiscal FI. The beneficiary can use this notice to forward to their private insurer, if applicable.

The VA or DOD hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

2. Outpatient Services

The amount paid by Medicare for emergency outpatient claims is obtained as follows:

- Eighty-five percent of the total covered charges is the estimated cost figure. The applicable Part B deductible is subtracted. Coinsurance is subtracted from the remainder.

- Subtracting the deductible from 85 percent of the total covered charges and applying the 20 percent coinsurance rate to the remainder obtains the patient's coinsurance amount. The hospital will be paid cost (85 percent of covered charges) minus deductible and coinsurance.

3. Part B Medical and Other Health Services

Part B medical and other health services, including hospital-based ambulance services whether hospital or beneficiary filed, may be covered and paid on a non-emergency basis. To calculate the amount paid by Medicare, the hospital subtracts the Part B deductible from the total covered charges and applies the 80 percent payment rate.

4. Special Letters for Partially or Totally Denied (Hospital-Filed) Claims for Emergency Inpatient Services

The patient receives a notice from CMS covering the emergency payment of a partially denied claim. A denial letter and a Part B explanation of benefits is sent to the patient. The FI includes its address on this letter.

B. Beneficiary Filed Claim

1. Emergency Inpatient Claims

The payment computation follows:

- Any noncovered accommodation charge is subtracted from the total accommodation charges. The amount of the inpatient deductible or coinsurance met on this bill is subtracted. Any remainder is multiplied by 60 percent.

- The total noncovered ancillary charge is subtracted from the total ancillary charge. Any inpatient deductible or coinsurance that remains is subtracted. The remainder is multiplied by 80 percent.

- The benefit amounts obtained are added.

2. Emergency Outpatient Services

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply the 80 percent payment rate.

3. Part B Medical and Other Health Services

Part B medical and other health services furnished by nonparticipating hospitals, including hospital-based ambulance services, may be covered and paid on an non-emergency basis.

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply an 80 percent payment rate.

4. Special Letters for Patient-Filed Claims for Emergency Inpatient Services

For emergency admissions to nonparticipating hospitals where direct payment is made to the patient, the FI sends the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made. Part B payments are made for ancillary services not covered by Part A and are also explained in a letter. This letter also explains the beneficiary's right of appeal.

The FI retains a duplicate of all notices sent for documentation in any appeals process. It enters the date the notice is released on both copies of all notices.

Sample paragraphs:

- "Enclosed is a check for $_____, which is the amount Medicare can pay for inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital)."

- "Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended)."

  "Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66 2/3 percent of the other charges which were not separately identified on the hospital bill."

- "Medicare does not pay (the first $ ____ of charges) (the first three pints of blood) ($ ____ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)"

- "If lifetime reserve days are used, add $ ___ a day from _____ to _____."

- "If you believe your Medicare hospital insurance should have covered all or more of your expenses, you may get in touch with us at the address shown on this letter."

- "If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You may make the request by mail to the address shown on this letter. If you come in person, please bring this notice with you."

- "This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from _____ through _____. These services are listed on the enclosed form."

- "If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended)."

- "We are enclosing a check for $ _____. This is your payment under Part B for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form."

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

120.1 - Payment for Services from Foreign Hospitals

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Hospital Filed Claim

A foreign hospital that elects to bill the Medicare program receives 100 percent of its customary charges, subject to applicable deductible and coinsurance amounts. The hospital establishes its customary charges for the services by submitting an itemized bill with each claim. This eliminates the need to file a cost report.

Regardless of the billing form used, the FI must:

- Recode the bill using revenue codes for the Form CMS-1450;

- Prepare an HUIP or HUOP input record for CWF; and

- Send a Medicare Summary Notice (MSN) to the beneficiary.

The foreign hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

Payment is subject to the official exchange rate on the date the patient is discharged.

B. Beneficiary Filed Claim

To calculate the amount paid by Medicare for Part B Hospital-Based Ambulance Claims, the hospital must subtract any unmet Part B deductible from the total covered charges and apply the 80 percent payment rate.

Payment to the beneficiary is subject to the official exchange rate on the date of discharge.

120.1.1 - Attending Physician's Statement and Documentation of Medicare Emergency

(Rev. 1, 10-01-03)

A3-3699.5, HO-491.4

Form CMS-1771 - go to http://www.cms.hhs.gov/forms/

Form CMS-2628 - go to http://www.cms.hhs.gov/forms/

120.2 - Designated FIs and Carriers

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The appropriate FI processes claims for services provided. The hospital forwards these claims and any subsequent appeals directly to the appropriate FI. The State in which a beneficiary lives will determine which FI to send a shipboard or foreign claim. If a beneficiary lives in one state but receives emergency services from a VA or DOD provider in another state, the claims should be processed in the state where the emergency services were rendered.

A – Fis

Canada	
New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services 2 Gannett Drive Portland, ME 04106-6911
Ontario	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5004 Great Falls, Montana 59403

British Columbia Northwest Territories Vancouver Yukon Territories	Premera Blue Cross 7001 - 220th S.W. Mountlake Terrace, Washington 98043
Mexico	
Western Mexico (Sonora and the Bajas	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156

See the Intermediary Carrier Directory at:
http://www.cms.hhs.gov/apps/contacts/incardir.asp

Domestic Emergency Claims and Veterans Administration/Department of Defense Claims, Foreign (other than Canada and Mexico) and Shipboard Claims

Region I	Associated Hospital Services, 2 Gannett Drive, South Portland, ME 04106-6911
Region III	Veritus Medicare Services 120 Fifth Avenue, Suite P5101 Pittsburgh, PA 15222
Region IV	Blue Cross and Blue Shield of Florida 532 Riverside Ave. 17th & 18th Floors Jacksonville, FL 32202
Region VI	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156
Region VII	Blue Cross and Blue Shield of Nebraska 7261 Mercy Rd. Omaha, NB 68124

	P.O. Box 3248 Main Post Office Station Omaha, NB 68180
Region IX	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804

Because there is no designated FI for Regions II, V, VIII, and X, the affected institutions must submit the claims to the servicing FI in their State. See http://www.cms.hhs.gov/apps/contacts/incardir.asp for a list of FIs.

B - Designated Carriers

The following carriers are designated to process claims for physicians' and ambulance services furnished in connection with a covered hospital stay in Canada and Mexico.

Canada

New Brunswick Newfoundland Nova Scotia Quebec	National Heritage Insurance Company 402 Otterson Drive Chico, CA 95928
Prince Edward Island	National Heritage Insurance Company 75 Sgt. William Terry Drive Hingham, MA 02044
Ontario	Wisconsin Physicians Service Insurance Corporation P.O. Box 8190 Madison, Wisconsin 53708 1601 Engel Street Madison, Wisconsin 53713
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5017 Great Falls, Montana 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Noridian Mutual Insurance Company 4305 13th Avenue, S.W. Fargo, North Dakota 58103

Mexico

Western Mexico (Sonora and the Bajas)	National Heritage Insurance Company 402 Otterson Drive Chico, CA 95928

Eastern Mexico
(Chihuahua, Coahuila,
Nuevo Leon, Tamaulipas, etc.)

Trailblazer Health Enterprises, LLC
8330 LBJ Freeway
Executive Center 3
Dallas, Texas 75243
P.O. Box 660156
Dallas, Texas 75266-0156

120.3 - Model Letters, Nonparticipating Hospital and Emergency Claims
(Rev. 1, 10-01-03)
A3-3699.7, HO-491.5

120.3.1 - Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year
(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:
_____

Dear _____:

Your election to bill the Medicare program for emergency services furnished to Medicare beneficiaries will expire on December 31. Payment for emergency services can be made to a nonparticipating hospital **only** if the hospital elects to receive reimbursement from Medicare for **all** emergency services furnished to Medicare beneficiaries in a calendar year.

If you elect to bill the program, please return to us in the enclosed self-addressed envelope a statement signed by an authorized official of your hospital stating that you elect to claim payment under the Medicare program. An election to bill cannot be withdrawn during the year. If a statement is not received by December 31, we will assume that you do not wish to continue to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting the FI serving nonparticipating hospitals in your State. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

Please contact us if you need any further information. In addition, if at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare FI for complete particulars.

Sincerely yours,

120.3.2 - Model Letter to Nonparticipating Hospital That Did Not Elect to Bill for Current Year

(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:
_____

Dear _____:

Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital **only** if the hospital elects to receive reimbursement from Medicare for **all** emergency services furnished to Medicare beneficiaries in a calendar year. Although your hospital did not elect to bill the program for the current calendar year, you may wish to bill for the coming year. If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

If we have not received a statement from you by December 31, we will assume that you do not wish to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

120.3.3 - Model Letter to Nonparticipating Hospital That Requests to Bill the Program

(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:

_____

Dear _____:

This refers to your inquiry concerning payment for emergency hospital services rendered to a Medicare beneficiary in a hospital which is not participating in the Medicare program. Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if you elect to receive reimbursement from Medicare for **all** emergency services furnished to Medicare beneficiaries in a calendar year. Your hospital may now choose to bill the program for all emergency services furnished to Medicare beneficiaries during the current calendar year, if you have not yet charged any Medicare beneficiary this year for emergency hospital services rendered to him.

If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

120.3.4 - Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital). This is because the (hospital) does not participate in the Medicare program and it has been determined that your treatment there does not qualify as emergency care. Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive **emergency** care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) that has a bed available and is equipped to handle the emergency.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, or if you believe the determination is not correct, you may request a reconsideration for hospital insurance. You must file your request within 6 months from the date of this notice. You may make the request through us.

120.3.5 - Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

This refers to your request for payment under Medicare for the services received while a patient at (hospital), from _____ through _____.

Payment can be made under the hospital insurance part of Medicare only for the costs of your hospitalization from _____ to _____.

The (hospital) does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive **emergency** care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on _____. At that time, your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, or you believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through us.

120.3.6 - Denial - Military Personnel/Eligible Dependents
(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

We are sorry, but payment cannot be made for your stay from_____ through_____ at (hospital).

Under the law, medical services that have been furnished by a Federal hospital to retired members of the armed services, or their eligible dependents, are not covered under the Medicare program.

If you have questions about this notice, or you believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through us at the above address.

Sincerely,

120.3.7 - Full Denial - Shipboard Claim - Beneficiary Filed
(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE

(FI'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number:_____

DETERMINATION ON SHIPBOARD SERVICES

We are sorry, but medical services provided on the (vessel/ship's name) cruise ship are not covered. The Medicare program can make payment for medically necessary shipboard services only if all of the following requirements are met:

1. The vessel is of American Registry;

2. The performing physician is registered with the Coast Guard to furnished professional medical services; and

3. The services are furnished while the ship is within the territorial waters of the United States (in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).

The vessels in the (name) line are not of American registry. For that reason, Medicare cannot make payment for the services in question.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have further questions concerning this issue, please send your correspondence to the above address.

Sincerely,

120.3.8 - Full Denial - Foreign Claim - Beneficiary Filed

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

MODEL DENIAL NOTICE
(FI'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____ Claim Number:_____

DETERMINATION ON FOREIGN HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital) in (country).

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have further questions concerning this issue, please send your correspondence to the above address.

Sincerely,

130 - Coordination With the Quality Improvement Organization (QIO)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Instructions regarding hospital interactions with QIOs have been relocated as follows:

- Instructions regarding HINNs are found in CMS Transmittal 594, which precedes the placement of full instructions in Chapter 30.

- Instructions regarding hospital billing for cases involving QIO review can be found in Chapter 1, section 150.2.

- Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

(Rev. 276, Issued 08-13-04, Effective: 10-01-04, Implementation: 01-03-05)

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by §125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F) and §305 of the Benefits Improvement and Protection Act of 2000 (BIPA), authorizes the implementation of a per discharge prospective payment system (PPS), through new §1886(j) of the Act, for inpatient rehabilitation hospitals and rehabilitation units now jointly referred to as inpatient rehabilitation facilities (IRFs).

The IRF PPS is effective for cost reporting periods beginning on or after January 1, 2002. IRF PPS payment rates include all costs of furnishing covered IRF services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR 413.85 and 413.86, bad debts, and other costs not covered under the PPS.

Effective for cost reporting periods beginning on or after October 1, 2004, the Medicare Modernization Act of 2003, Public Law 108-173, section 405(g) established that CAHs may open rehabilitation distinct part units. These IRFs will also be paid under the IRF PPS.

140.1 - Medicare IRF Classification Requirements

(Rev. 347, Issued: 10-29-04, Effective: N/A, Implementation: 11-29-04)

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a prospective payment system (PPS) under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (referred to as an inpatient rehabilitation facility (IRF)). Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of

the Act give the Secretary the discretion to define an IRF. The regulations at 42 CFR 412.23(b), 412.25, 412.29, and 412.30, specify the criteria for a provider to be classified as an IRF. Hospitals and units meeting those criteria are eligible to be paid on a PPS basis as an IRF under the IRF PPS.

A determination by the Regional Office (RO) that a facility is classified as an IRF applies to the entire cost reporting period for which the determination is made. The ROs generally make these determinations on an annual basis at the start of a facility's cost reporting period. If a determination is made by the RO to change the classification of a facility, the IRF status classification remains in effect for the duration of that cost reporting period. How a hospital or unit is classified takes effect only at the start of the facility's cost reporting period.

An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. In addition, the results of the verification procedure are used in determining each facility's classification status for the next cost reporting period. If a facility fails to meet the criteria necessary to be classified as an IRF, but meets the criteria to be classified as an acute care hospital or acute care hospital unit, it may be paid under the acute care hospital PPS. For the services furnished to a patient who was admitted when the facility was classified as an IRF, but who is discharged after the facility is no longer classified as an IRF, payment to the facility will be from the applicable payment system the facility is paid under when the facility is no longer classified as an IRF. The IRFs that have already been excluded from the acute care hospital PPS need not reapply to be classified as an IRF. However, on an annual basis an IRF must self-attest, except for the criteria specified below in §140.1.1B, that it still meets the criteria for being classified as an IRF. The fiscal intermediary (FI) is always required to verify that an IRF has met the criteria specified below in §140.1.1B. The facility must have approval from the RO and the State Agency prior to making changes in operations. All IRFs are notified by letter by the appropriate CMS RO of the self-attestation procedures, and other procedures and requirements that apply to them. The FI is not responsible for monitoring or enforcing IRF self-attestation procedures.

140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Hospitals

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A rehabilitation hospital is excluded from the acute care hospital PPS if it meets all of the following criteria.

A. The hospital has in effect an agreement to participate as a hospital.

B. During a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) the hospital treated an inpatient population that met or exceeded the following percentages:

1. For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the hospital must have served an inpatient population of whom at least 50 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

2. For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2007, the hospital must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at § 140.1.1C.

3. For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the hospital must have served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified below at §140.1.1C.

4. For cost reporting periods beginning on or after July 1, 2008, the hospital must have served an inpatient population of whom of at least 75 percent required intensive rehabilitative services for the treatment of one or more of the medical conditions specified below at §140.1.1C.

(a) Section 140.1.4B3(a) specifies that in certain situations some inpatients will not be considered part of the IRF's total inpatient population when the determination is being made regarding compliance with the requirements specified above in §140.1.1B1 to 140.1.1B4.

C. List of Medical Conditions:

1. Stroke.

2. Spinal cord injury.

3. Congenital deformity.

4. Amputation.

5. Major multiple trauma.

6. Fracture of femur (hip fracture).

7. Brain injury.

8. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

9. Burns.

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive

rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. An appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings must consist of a course of rehabilitation therapy of at least 3 weeks minimum duration with at least two individual (non-group) therapy sessions per week targeting all clinically impaired joints supported by documentation in the medical record of all such services with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay, or 20 calendar days immediately preceding an IRF admission. However, there may be cases when, in the FI's judgment, the preceding interpretation of what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings should not be used. In these cases, the FI has the discretion to develop, document, and use another interpretation, which is based upon local practices and more current clinical information, that interprets or defines what the FI considers is an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings. Regardless of which interpretation or definition is used by the FI with respect to what is considered an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings, the course of therapy itself should have the goal of completing the rehabilitation, not preparing a patient for surgery. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

For the medical conditions specified above in subsections 10, 11, and 12, the FI has the discretion to review documentation in order to assure that an inpatient has completed an

appropriate, aggressive, and sustained course of therapy or services in less intensive rehabilitation settings. We expect that the IRF will obtain copies of the therapy notes from the outpatient therapy or therapy in another less intensive setting and place it in the patient's inpatient chart (in a section for prior records). We believe that these prior records will be primarily used by therapists and others caring for the inpatient in the IRF, but will also be available to FI staff who reviews the medical records for compliance with the requirements specified above in §140.1.1B.

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:

a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

b. The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

c. The patient is age 85 or older at the time of admission to the IRF.

D. A hospital that seeks classification as an IRF for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital must provide a written certification that the inpatient population it intends to serve meets the requirements specified above in §140.1.1B, instead of showing that it has treated the inpatient population specified above in §140.1.1B during its most recent 12-month cost reporting period. The written certification is also effective for a cost reporting period of not less than 1 month and not more than 11 months occurring between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period. However, if the hospital does not actually meet the requirements specified above in §140.1.1B during any cost reporting period that it has certified it would meet the requirements specified above in §140.1.1B, then CMS will adjust the payments associated with that cost reporting period as described below in §140.1.8.

E. The hospital has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment.

F. The hospital ensures that patients receive close medical supervision and furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social or psychological services, and orthotic and prosthetic services.

G. The hospital has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

H. The hospital uses a coordinated multi-disciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record, to note the patient's status in relationship to goal attainment, and ensures that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.

I. The hospital has a director of rehabilitation who provides services to the hospital and its inpatients on a full time basis, is a Doctor of Medicine or Osteopathy, is licensed under state law to practice medicine or surgery, and has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

140.1.2 - Counting A Comorbidity As One Of The Listed Medical Conditions

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay. A patient with a comorbidity may be counted as part of the inpatient population that counts towards the required applicable percentage specified above in §140.1.1B if:

A. The patient is admitted for inpatient rehabilitation for a medical condition that is not one of the conditions specified in above in sub-section 140.1.1C.

B. The patient has a comorbidity that falls in one of the medical conditions specified above in sub-section 140.1.1C; and

C. The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under the IRF PPS, and that cannot be appropriately performed in another care setting covered under Medicare.

For cost reporting periods beginning on or after July 1, 2008, a patient's comorbidity is not included in the inpatient population that is used to determine the compliance percentage specified above in §140.1.1B.

140.1.3 - Criteria That Must Be Met By Inpatient Rehabilitation Units

(Rev. 221, 06-25-04)

To be excluded from the acute care hospital PPS an inpatient rehabilitation unit must meet the criteria in paragraphs A through Q below.

A. The inpatient rehabilitation unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the acute care hospital PPS.

B. The inpatient rehabilitation unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. The inpatient rehabilitation unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. (However, the medical records of unit patients need not be physically separate from the records of patients in the acute care part of the hospital, and it is not necessary to create a second medical record when a patient is moved from the acute care part of the hospital to the excluded unit, or vice versa. The record must indicate the dates of the admission and discharge for patients of the unit.) The inpatient rehabilitation unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the inpatient rehabilitation unit.

D. If state law provides special licensing requirements for rehabilitation units, the inpatient rehabilitation unit must be licensed in accordance with the applicable requirements.

E. The hospital's utilization review plan must include separate standards for the type of care offered by the inpatient rehabilitation unit.

F. The beds assigned to the inpatient rehabilitation unit must be physically separate from (i.e., not co-mingled with) beds not included in the unit.

G. The hospital must have enough beds not excluded from the acute care hospital PPS to permit the provision of adequate cost information. The FI has discretion as to how to apply generally accepted accounting principles when making this analysis.

H. The inpatient rehabilitation unit and the hospital in which it is located must be serviced by the same FI.

I. The inpatient rehabilitation unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. The accounting system of the hospital in which the inpatient rehabilitation unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

Compliance with the criteria in items H, I, and J above may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the FI, that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion from the acute care hospital PPS, if approved, applies.

K. The cost report for the hospital must include the costs of the inpatient rehabilitation unit, covering the same fiscal period as the hospital, and use the same method of cost apportionment as the hospital.

L. As of the first day of the first cost reporting period for which all other exclusion requirements are met, the inpatient rehabilitation unit must be fully equipped, staffed, and must be capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the acute care hospital PPS.

N. Except as specified below in paragraph O, the inpatient rehabilitation unit must have treated, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) an inpatient population that meets the requirements specified above in §140.1.1B.

O. For the first cost reporting period in which a currently participating hospital seeks exclusion from the acute care hospital PPS of a new inpatient rehabilitation unit, it may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §140.1.1B above, instead of showing that it has treated such a population during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI). For the purpose of this provision, a unit is considered to be a new inpatient rehabilitation unit only if the hospital has not previously sought exclusion for any rehabilitation unit, and has obtained approval for added bed capacity under its state licensure and its approved Medicare provider agreement. A unit of a currently participating hospital that includes some beds that were previously licensed and certified, and some new beds, is recognized as a new inpatient rehabilitation unit only if more than one-half of the beds are new.

P. The unit must meet the requirements specified above in §140.1.1E-H.

Q. The unit must have a Director of Rehabilitation who has the qualifications specified above in §140.1.1I, and provides services to the unit and its inpatients for at least 20 hours per week. If a rehabilitation unit serves both inpatients and outpatients through a single integrated unit, the time spent by the director in performing administrative duties for the entire unit, counts toward the direction requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

The criteria specified in paragraphs A through Q above are used to determine whether a part of a hospital qualifies for exclusion from the acute care hospital PPS. An excluded unit must be established as a separate cost entity for cost reporting purposes.

If a hospital wishes to have a unit excluded from the acute care hospital PPS for a cost reporting period, it must notify its FI before the start of the cost reporting period of the particular areas it has designated as the unit, and of the square footage and number of beds in the unit, and the FI, or RO, will inform the IRF of the proper procedures. This notice must be sent to the FI at the same time the notice is sent to the RO regarding the request for exclusion from the acute care hospital PPS and must identify the designated space through the use of room numbers and/or bed numbers. The notice must be sent no later than 5 months before the beginning of the hospital's cost reporting period. The RO determines, based on information obtained from the State Survey Agency and the hospital's FI, whether the unit qualifies for exclusion from the acute care hospital PPS. If the RO disapproves the exclusion, it notifies the hospital prior to the start of the hospital's next cost reporting period. If the RO approves the exclusion, it notifies the hospital prior to the start of the hospital's next cost reporting period, and notifies the FI of the unit's exclusion from the acute care hospital PPS and the provider's identification number. The hospital's self-attestation that it meets the applicable criteria, which qualifies the unit to be excluded from the acute care hospital PPS, is subject to verification by the RO, the State Agency, and the FI. An IRF that has already been excluded from the acute care hospital PPS is always subject to verification that it continues to meet the criteria necessary to allow the facility to be excluded from the acute care hospital PPS. The results of the verification procedure are used in determining each facility's classification status for the next cost reporting period.

After the initial classification as an IRF, changes in the amount of the space occupied by the unit, or in the number of beds in the unit, are recognized for purposes of the exclusion from the acute care hospital PPS only at the start of a cost reporting period.

140.1.4 - Verification Process Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria

(Rev. 1135, Issued: 12-22-06; Effective: 07-01-05; Implementation: 03-22-07)

A. Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period. In general, the RO and FI will use data from a most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and FI will notify the facility regarding which most recent, consecutive, and appropriate 12-month period will be used as the review time period when they determine if the criteria used to classify a facility as an IRF was met. The RO and FI will begin 4 months prior to the start of the facility's next cost reporting time period the process necessary to verify all of the criteria used to classify a facility as an IRF. If for any reason the RO or FI require additional time to complete their compliance review, the RO and FI must consult with the facility prior to changing the compliance time period subject to review, and before using patient data that may overlap patient data from the previous 12-month review period.

The table below entitled "Table Of Compliance Review Periods" illustrates the time spans associated with an IRF's compliance review period and the compliance percentage threshold that must be met during each compliance review period. Depending on the specific compliance review period, a compliance review period may include a span of time from only one cost reporting period, or a compliance review period may span periods of time from two cost reporting periods.

For cost reporting periods that start on or after July 1, 2008, the compliance percentage threshold that the IRF must meet is 75 percent. However, for cost reporting periods that start on or after July 1, 2004, but not later than June 30, 2008, the compliance percentage threshold that an IRF must meet changes in accordance with the requirements specified in §140.1.1B. Below in (a) through (f) are examples of how the compliance percentage is calculated when the compliance review period is associated with one or more cost reporting periods. Following the examples is a "Table of Compliance Review Periods" that in most cases can be used to ascertain what compliance percentage must be met for a specific time period.

a. When the cost reporting period starts on or after July 1, 2004, and the compliance review period is associated with only one cost reporting period.

When an IRF has a cost reporting period that starts on or after July 1, 2004, and the compliance review period is associated with only one cost reporting period (for example, but not only, a new IRF), the compliance percentage is the percentage of the cases in the total compliance review period that met at least one of the medical conditions listed in §140.1.1C. For example, for an IRF that has a cost reporting period that started on July 1, 2004, and ends on June 30, 2005, the compliance review period is July 1, 2004, to February 28, 2005, and the compliance percentage is the percentage of cases from July 1, 2004, to February 28, 2005, that met at least one of the medical conditions listed in §140.1.1C.

(1) Guideline To Determine The Compliance Review Period For IRFs With Cost Reporting Periods That Start Between July 1, 2004, and October 31, 2004. If an IRF has a cost reporting period beginning on or after July 1, 2004, but not later than November 1, 2004, the RO and FI cannot collect 12 months of the most recent, consecutive, and appropriate data from a period falling completely after, as opposed to before, July 1, 2004, and have the 4 months of time necessary to make the compliance determination. To illustrate, to determine whether a hospital with a cost reporting period beginning on July 1, 2004, should continue to be classified as an IRF for the cost reporting period beginning on July 1, 2005, the RO and FI would have to start their compliance review 4 months prior to July 1, 2005, which means that the compliance review will start on March 1, 2005. As stated above, in general the RO and FI will use 12 months of data from the most recent, consecutive, and appropriate time period that is after July 1, 2004. Starting the compliance review on March 1, 2005, means that the RO and FI must use data from the previous 12 months, which is March 1, 2004, to February 28, 2005. However, using data from March 1, 2004, to February 28, 2005, would result in the RO and FI using 4 months of data, that is, March 1, 2004, to June 30, 2004, from a time period that is

before July 1, 2004. Therefore, to avoid using data from a time period that is prior to July 1, 2004, an IRF with a cost reporting period that starts between July 1, 2004, and October 31, 2004, will have a compliance review period, as generally illustrated below in the Table of Compliance Review Periods, that is less than 12-months.

b. When the cost reporting periods starts on or after July 1, 2004, but not later than June 30, 2005 and the compliance review period spans two cost reporting periods.

When an IRF has a cost reporting period that starts on or after July 1, 2004, but not later than June 30, 2005, and the compliance review period spans two cost reporting periods, the compliance percentage is the percentage of the cases in the total compliance review period that met at least one of the medical conditions listed in §140.1.1C. For example, for an IRF that has a cost reporting period than starts on January 1, 2005, and ends on December 31, 2005, the compliance review period is September 1, 2004, to August 31, 2005, and the compliance percentage is the percentage of cases from September 1, 2004, to August 31, 2005, that met at least one of the medical conditions listed in §140.1.1C.

c. When a cost reporting period starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods the compliance percentage is calculated using either of the following two methods. The provider may meet the compliance threshold requirements that are described more fully above in §140.1.1B by use of either of these methods.

(1) When an IRF has a cost reporting period that starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, and the IRF had a patient population in each portion of the compliance review period, each portion of the compliance review period must separately meet the compliance percentage threshold of the cost reporting period that includes that portion of time of the compliance review period, in order for a determination to be made that the compliance requirements were met for the entire compliance review period.

The following is an example illustrating how the criteria directly above would be used to determine if the compliance requirements were met.

- As illustrated in the table below entitled "Table Of Compliance Review Periods," an IRF that has a cost reporting period that started on July 1, 2004, must meet, as described more fully above in §140.1.1B, a compliance threshold of 50 percent for the cost reporting period of July 1, 2004, to June 30, 2005. In addition, for the next cost reporting period that starts on July 1, 2005, the IRF must meet, as described more fully above in §140.1.1B, a compliance threshold of 60 percent for the cost reporting period of July 1, 2005, to June 30, 2006.

- For the cost reporting period that starts on July 1, 2005, the IRF has a compliance review period consisting of March 1, 2005, to February 28, 2006. In this example,

the time period from March 1, 2005, to June 30, 2005, is part of the IRF's cost reporting period that started on July 1, 2004, and ends on June 30, 2005, and the time period from July 1, 2005, to February 28, 2006, is part of the IRF's cost reporting period that starts on July 1, 2005, and ends on June 30, 2006.

- For the portion of the compliance review period from March 1, 2005, to June 30, 2005, the compliance percentage threshold that must be met is 50 percent. Similarly, for the portion of the compliance review period from July 1, 2005, to February 28, 2006, the compliance percentage threshold that must be met is 60 percent.

- If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005, to June 30, 2005, portion of the compliance review time period, or the compliance percentage threshold of 60 percent for the July 1, 2005, to February 28, 2006, portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005, to February 28, 2006.

(2) When an IRF has a cost reporting period that starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, and the IRF had a patient population in each portion of the compliance review period, the two portions of the compliance review period may be used to calculate one weighted average compliance percentage for the entire 12-month compliance review period. The weighted average compliance percentage that is calculated for the entire12-month compliance review period will be used to determine if the facility met the compliance threshold requirements that are described more fully above in §140.1.1B.

- For example, an IRF with a cost reporting period starting on 08/01/2005 has a compliance review period of 04/01/2005 to 03/31/2006 but that 12-month period is divided into two portions which are 04/01/2005 to 07/31/2005 and 08/01/2005 to 03/31/2006. In this example, during the 04/01/2005 to 07/31/2005 portion of time 45 percent of the cases met at least one of the medical conditions listed above in §140.1.1C, and during the 08/01/2005 to 03/31/2006 portion of time 80 percent of the cases met at least one of the medical conditions listed in §140.1.1C. The weighted average compliance percentage from the two portions of time may be calculated as follows:

  4/12 = 0.333 which is rounded to 0.33
  8/12 = 0.666 which is rounded to 0.67

  0.33 X 45% = 0.1485
  0.67 X 80% = 0.5360

  0.1485 + 0.5360 = 0.6845 which is rounded to 68%

In accordance with the compliance threshold requirements that are described more fully above in §140.1.1B, for the cost reporting period starting on 08/01/2005 the compliance threshold was 60 percent. During the 12-month compliance review period of 04/01/2005 to 03/31/2006 the weighted average compliance percentage the IRF attained was 68 percent and, thus, for the cost reporting period that started on 08/01/2005 the IRF met the compliance threshold. Other weighted averaging techniques may also be used to determine the weighted average compliance percentage, as long as the technique that is used is mathematically sound and consistent with logical mathematically reasoning.

d. When the cost reporting periods starts on or after July 1, 2006, but not later than June 30, 2007 and the compliance review period spans two cost reporting periods.

When an IRF has a cost reporting period that starts on or after July 1, 2006, but not later than June 30, 2007, and the compliance review period spans two cost reporting periods, the compliance percentage attained is the percentage of the cases in the total 12-month compliance review period that met at least one of the medical conditions listed in §140.1.1C. The compliance review period is not divided into two portions of time because for cost reporting periods starting on or after July 1, 2006, nut not later than June 30, 2007, the compliance threshold that must be met is 60 percent. For example, for an IRF that has a cost reporting period than starts on August 1, 2006, and ends on July 31, 2007, the compliance review period is April 1, 2006, to March 31, 2007, and the compliance percentage is the percentage of cases from April 1, 2006, to March 31, 2007, that met at least one of the medical conditions listed in §140.1.1C.

e. When a cost reporting period starts on or after July 1, 2007, but not later than June 30, 2009, and the compliance review period spans two cost reporting periods the compliance percentage is calculated using either of the following methods. The provider may meet the compliance threshold requirements that are described more fully above in §140.1.1B by use of either of these methods.

(1) When an IRF has a cost reporting period that starts on or after July 1, 2007, but not later than June 30, 2009, and the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, and the IRF had a patient population in each portion of the compliance review period, each portion of the compliance review period must separately meet the compliance percentage threshold of the cost reporting period that includes that portion of time of the compliance review period, in order for a determination to be made that the compliance requirements were met for the entire compliance review period.

The following is an example illustrating how the criteria directly above would be used to determine if the compliance requirements were met.

- As illustrated in the table below entitled "Table Of Compliance Review Periods," an IRF that has a cost reporting period that started on July 1, 2007, must meet, as described more fully above in §140.1.1B, a compliance threshold of 65 percent for the cost reporting period of July 1, 2007, to June 30, 2008. In addition, for the next cost reporting period that starts on July 1, 2008, the IRF must meet, as

described more fully above in §140.1.1B, a compliance threshold of 75 percent for the cost reporting period of July 1, 2008, to June 30, 2009.

- For the cost reporting period that starts on July 1, 2007, the IRF has a compliance review period consisting of March 1, 2007, to February 29, 2008. In this example, the time period from March 1, 2007, to June 30, 2007, is part of IRF's cost reporting period that started on July 1, 2006, and ends on June 30, 2007, and the time period from July 1, 2007, to February 29, 2008, is part of the IRF's cost reporting period that starts on July 1, 2007, and ends on June 30, 2008.

- For the portion of the compliance review period from March 1, 2007, to June 30, 2007, the compliance percentage threshold that must be met is 60 percent. Similarly, for the portion of the compliance review period from July 1, 2007, to February 29, 2008, the compliance percentage threshold that must be met is 65 percent.

- If the IRF does not meet the compliance percentage threshold of 60 percent for the March 1, 2007, to June 30, 2007, portion of the compliance review time period, or the compliance percentage threshold of 65 percent for the July 1, 2007, to February 29, 2008, portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2007, to February 29, 2008.

(2) When an IRF has a cost reporting period that starts on or after July 1, 2007,but not later than June 30, 2009, and the compliance review period spans two cost reporting periods, and the compliance review period is divided into two portions of time, and the IRF had a patient population in each portion of the compliance review period, the two portions of the compliance review period may be used to calculate one weighted average compliance percentage for the entire 12-month compliance review period. The weighted average compliance percentage that is calculated for the entire12-month compliance review period will be used to determine if the facility met the compliance threshold requirements that are described more fully above in §140.1.1B. For example, an IRF with a cost reporting period starting on 08/01/2007 has a compliance review period of 04/01/2007 to 03/31/2008 but that 12-month period is divided into two portions which are 04/01/2007 to 07/31/2007 and 08/01/2007 to 03/31/2008. In this example, during the 04/01/2007 to 07/31/2007 portion of time 45 percent of the cases met at least one of the medical conditions listed above in §140.1.1C, and during the 08/01/2007 to 03/31/2008 portion of time 80 percent of the cases met at least one of the medical conditions listed in §140.1.1C. The weighted average compliance percentage from the two portions of time may be calculated as follows:

4/12 = 0.333 which is rounded to 0.33
8/12 = 0.666 which is rounded to 0.67

0.33 X 45% = 0.1485
0.67 X 80% = 0.5360

0.1485 + 0.5360 = 0.6845 which is rounded to 68%

In accordance with the compliance threshold requirements that are described more fully above in §140.1.1B, for the cost reporting period starting on 08/01/2007 the compliance threshold was 65 percent. During the 12-month compliance review period of 04/01/2007 to 03/31/2008 the weighted average compliance percentage the IRF attained was 68 percent and, thus, for the cost reporting period that started on 08/01/2007 the IRF met the compliance threshold. Other weighted averaging techniques may also be used to determine the weighted average compliance percentage.

f. When the cost reporting periods starts on or after July 1, 2009, and the compliance review period spans two cost reporting periods.

When an IRF has a cost reporting period that starts on or after July 1, 2009, and the compliance review period spans two cost reporting periods, the compliance percentage is the percentage of the cases in the total 12-month compliance review period that met at least one of the medical conditions listed in §140.1.1C. For example, for an IRF that has a cost reporting period than starts on August 1, 2009, and ends on July 31, 2010, the compliance review period is April 1, 2009, to March 31, 2010, and the compliance percentage is the percentage of cases from April 1, 2009, to March 31, 2010, that met at least one of the medical conditions listed in §140.1.1C.

2. Table Of Compliance Review Periods. For a facility that has been classified as an IRF, but is not a "new" IRF as defined below in §140.1.7, the following table illustrates the compliance review periods and the compliance percentage threshold that must be met during an entire compliance review period or portion of an entire compliance review period.

Table Of Compliance Review Periods

For Cost Reporting Periods Beginning On:	Review Period: (Admissions or Discharges During)	Number Of Months In Review Period	Compliance Percentage Threshold Associated With A Compliance Review Period Or Portions Of the Compliance Review Period	Compliance Determination Applies To Cost Reporting Period Beginning On:
07/01/2004	07/01/2004-02/28/2005	8	07/01/2004 to 02/28/2005: 50 %	07/01/2005
08/01/2004	07/01/2004-03/31/2005	9	07/01/2004 to 03/31/2005: 50 %	08/01/2005
09/01/2004	07/01/2004-04/30/2005	10	07/01/2004 to 04/30/2005: 50 %	09/01/2005
10/01/2004	07/01/2004-05/31/2005	11	07/01/2004 to 05/31/2005: 50 %	10/01/2005
11/01/2004	07/01/2004-	12	07/01/2004 to 06/30/2005: 50 %	11/01/2005

	06/30/2005			
12/01/2004	08/01/2004-07/31/2005	12	08/01/2004 to 07/31/2005: 50 %	12/01/2005
01/01/2005	09/01/2004-08/31/2005	12	09/01/2004 to 08/31/2005: 50 %	01/01/2006
02/01/2005	10/01/2004-09/30/2005	12	10/01/2004 to 09/30/2005: 50 %	02/01/2006
03/01/2005	11/01/2004-10/31/2005	12	11/01/2004 to 10/31/2005: 50 %	03/01/2006
04/01/2005	12/01/2004-11/30/2005	12	12/01/2004 to 11/30/2005: 50 %	04/01/2006
05/01/2005	01/01/2005-12/31/2005	12	01/01/2005 to12/31/2005: 50 %	05/01/2006
06/01/2005	02/01/2005-01/31/2006	12	02/01/2005 to 01/31/2006: 50 %	06/01/2006
07/01/2005	03/01/2005-02/28/2006	12	03/01/2005 to 06/30/2005: 50 % 07/01/2005 to 02/28/2006: 60 %	07/01/2006
08/01/2005	04/01/2005-03/31/2006	12	04/01/2005 to 07/31/2005: 50 % 08/01/2005 to 03/31/2006: 60 %	08/01/2006
09/01/2005	05/01/2005-04/30/2006	12	05/01/2005 to 08/31/2005: 50 % 09/01/2005 to 04/30/2006: 60 %	09/01/2006
10/01/2005	06/01/2005-05/31/2006	12	06/01/2005 to 09/30/2005: 50 % 10/01/2005 to 05/31/2006: 60 %	10/01/2006
11/01/2005	07/01/2005-06/30/2006	12	07/01/2005 TO 10/31/2005: 50 % 11/01/2005 TO 06/30/2006: 60 %	11/01/2006
12/01/2005	08/01/2005-07/31/2006	12	08/012005 TO 11/30/2005: 50 % 12/01/2005 TO 07/31/2006: 60 %	12/01/2006
01/01/2006	09/01/2005-08/31/2006	12	09/01/2005 TO 12/31/2005: 50 % 01/01/2006 TO 08/31/2006: 60 %	01/01/2007
02/01/2006	10/01/2005-09/30/2006	12	10/01/2005 TO 01/31/2006: 50 % 02/01/2006 TO 09/30/2006: 60 %	02/01/2007
03/01/2006	11/01/2005-10/31/2006	12	11/01/2005 TO 02/28/2006: 50 % 03/01/2006 TO 10/31/2006: 60 %	03/01/2007
04/01/2006	12/01/2005-11/30/2006	12	12/01/2005 TO 03/31/2006: 50 % 04/01/2006 TO 11/30/2006: 60 %	04/01/2007
05/01/2006	01/01/2006-12/31/2006	12	01/01/2006 TO 04/30/2006: 50 % 05/01/2006 TO 12/31/2006: 60 %	05/01/2007
06/01/2006	02/01/2006-01/31/2007	12	02/01/2006 TO 05/31/2006: 50 % 06/01/2006 TO 01/31/2007: 60 %	06/01/2007
07/01/2006	03/01/2006-02/28/2007	12	03/01/2006 to 02/28/2007: 60 %	07/01/2007
08/01/2006	04/01/2006-03/31/2007	12	04/01/2006 to 03/31/2007: 60 %	08/01/2007
09/01/2006	05/01/2006-04/30/2007	12	05/01/2006 to 04/30/2007: 60 %	09/01/2007

10/01/2006	06/01/2006-05/31/2007	12	06/01/2006 to 05/31/2007: 60 %	10/01/2007
11/01/2006	07/01/2006-06/30/2007	12	07/01/2006 to 06/30/2007: 60 %	11/01/2007
12/01/2006	08/01/2006-07/31/2007	12	08/01/2006 to 07/31/2007: 60 %	12/01/2007
01/01/2007	09/01/2006-08/31/2007	12	09/01/2006 to 08/31/2007: 60 %	01/01/2008
02/01/2007	10/01/2006-09/30/2007	12	10/01/2006 to 09/30/2007: 60 %	02/01/2008
03/01/2007	11/01/2006-10/31/2007	12	11/01/2006 to 10/31/2007: 60 %	03/01/2008
04/01/2007	12/01/2006-11/30/2007	12	12/01/2006 to 11/30/2007: 60 %	04/01/2008
05/01/2007	01/01/2007-12/31/2007	12	01/01/2007 to 12/31/2007: 60 %	05/01/2008
06/01/2007	02/01/2007-01/31/2008	12	02/01/2007 to 01/31/2008: 60 %	06/01/2008
07/01/2007	03/01/2007-02/29/2008	12	03/01/2007 to 06/30/2007: 60 % 07/01/2007 to 02/29/2008: 65 %	07/01/2008
08/01/2007	04/01/2007-03/31/2008	12	04/01/2007 to 07/31/2007: 60 % 08/01/2007 to 03/31/2008: 65 %	08/01/2008
09/01/2007	05/01/2007-04/30/2008	12	05/01/2007 to 08/31/2007: 60 % 09/01/2007 to 04/30/2008: 65 %	09/01/2008
10/01/2007	06/01/2007-05/31/2008	12	06/01/2007 to 09/30/2007: 60 % 10/01/2007 to 05/31/2008: 65 %	10/01/2008
11/01/2007	07/01/2007-06/30/2008	12	07/01/2007 to 10/31/2007: 60 % 11/01/2007 to 06/30/2008: 65 %	11/01/2008
12/01/2007	08/01/2007-07/31/2008	12	08/01/2007 to 11/30/2007: 60 % 12/01/2007 to 07/31/2008: 65 %	12/01/2008
01/01/2008	09/01/2007-08/31/2008	12	09/01/2007 to 12/31/2007: 60 % 01/01/2008 to 08/31/2008: 65 %	01/01/2009
02/01/2008	10/01/2007-09/30/2008	12	10/01/2007 to 01/31/2008: 60 % 02/01/2008 to 09/30/2008: 65 %	02/01/2009
03/01/2008	11/01/2007-10/31/2008	12	11/01/2007 to 02/29/2008: 60 % 03/01/2008 to 10/31/2008: 65 %	03/01/2009
04/01/2008	12/01/2007-11/30/2008	12	12/01/2007 to 03/31/2008: 60 % 04/01/2008 to 11/30/2008: 65 %	04/01/2009
05/01/2008	01/01/2008-12/31/2008	12	01/01/2008 to 04/30/2008: 60 % 05/01/2008 to 12/31/2008: 65 %	05/01/2009
06/01/2008	02/01/2008-01/31/2009	12	02/01/2008 to 05/31/2008: 60 % 06/01/2008 to 01/31/2009: 65 %	06/01/2009
07/01/2008	03/01/2008-02/28/2009	12	03/01/2008 to 06/30/2008: 65 % 07/01/2008 to 02/28/2009: 75 %	07/01/2009
08/01/2008	04/01/2008-03/31/2009	12	04/01/2008 to 07/31/2008: 65 % 08/01/2008 to 03/31/2009: 75 %	08/01/2009

09/01/2008	05/01/2008- 04/30/2009	12	05/01/2008 to 08/31/2008: 65 % 09/01/2008 to 04/30/2009: 75 %	09/01/2009
10/01/2008	06/01/2008- 05/31/2009	12	06/01/2008 to 09/30/2008: 65 % 10/01/2008 to 05/31/2009: 75 %	10/01/2009
11/01/2008	07/01/2008- 06/30/2009	12	07/01/2008 to 10/31/2008: 65 % 11/01/2008 to 06/30/2009: 75 %	11/01/2009
12/01/2008	08/01/2008- 07/31/2009	12	08/01/2008 to 11/30/2008: 65 % 12/01/2008 to 07/31/2009: 75 %	12/01/2009
01/01/2009	09/01/2008- 08/31/2009	12	09/01/2008 to 12/31/2008: 65 % 01/01/2009 to 08/31/2009: 75 %	01/01/2010
02/01/2009	10/01/2008- 09/30/2009	12	10/01/2008 to 01/31/2009: 65 % 02/01/2009 to 09/30/2009: 75 %	02/01/2010
03/01/2009	11/01/2008- 10/31/2009	12	11/01/2008 to 02/28/2009: 65 % 03/01/2009 to 10/31/2009: 75 %	03/01/2010
04/01/2009	12/01/2008- 11/30/2009	12	12/01/2008 to 03/31/2009: 65 % 04/01/2009 to 11/30/2009: 75 %	04/01/2010
05/01/2009	01/01/2009 12/31/2009-	12	01/01/2009 to 04/30/2009: 65 % 05/01/2009 to 12/31/2009: 75 %	05/01/2010
06/01/2009	02/01/2009- 01/31/2010	12	02/01/2009 to 05/31/2009:65 % 06/01/2009 to 01/31/2010: 75 %	06/01/2010
07/01/2009	03/01/2009- 02/28/2010	12	03/01/2009 to 02/28/2010: 75 %	07/01/2010
08/01/2009	04/01/2009- 03/31/2010	12	04/01/2009 to 03/31/2010: 75 %	08/01/2010

For cost reporting periods starting after August 1, 2009, the compliance threshold that must be met is 75 percent, and the compliance review period will be a 12-month time period that is not divided into two portions of time.

As illustrated in the above table, if a cost reporting period starts on or after July 1, 2004, and not later than November 1, 2004, data from a compliance review period that is less than 12 months in length will be used to determine if the facility met all of the criteria necessary to be classified as an IRF for the next cost reporting period. For cost reporting periods beginning on or after November 1, 2004, data from the most recent, consecutive, and appropriate 12-month period of time (as defined by CMS or the fiscal intermediary) would be used, giving the ROs and FIs a 4-month time period to administer a compliance determination.

3. Guideline For Determining The Compliance Review Period Of A Facility Classified As A New IRF, And For An IRF Expanding Its Size. In order for an IRF to be classified as a new IRF, or to add new bed capacity, it must meet the criteria specified in the regulations and below in §140.1.7. A facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that is similar to an IRF whose cost reporting period begins on July 1, 2004. In other words, a facility classified as a new IRF, or adding new bed capacity, will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of

its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2004, and is a new IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, a facility classified as a new IRF, or adding new bed capacity, will have an initial compliance review period that is 8 months in length, in order to allow the RO and FI a 4-month time period to make and administer a compliance determination.

The compliance threshold for a facility classified as a new IRF, or adding new bed capacity, that had a cost reporting period that started on or after June 30, 2003, but not later than July 1, 2004, will be 50 percent.

4. Guideline For Determining The Compliance Review Period Of A Facility Undergoing Conversion To An IRF. A facility undergoing the conversion process in order to be classified as an IRF, will have a compliance review period that is similar to an IRF whose cost reporting periods begins on July 1, 2004. In other words, a facility undergoing the conversion process in order to be classified as an IRF, will have a compliance review period that starts immediately when the cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2004, and is undergoing the conversion process in order to be classified as an IRF, its compliance review period would start on July 1, 2004, and end on February 28, 2005. Thus, if a facility is undergoing the conversion process in order to be classified as an IRF, it will have a compliance review period that is 8 months in length, in order to allow the RO and FI a 4-month time period to make and administer a compliance determination.

The compliance threshold for a facility undergoing the conversion process in order to be classified as an IRF that had a cost reporting period that started on or after June 30, 2003, but not later than July 1, 2004, will be 50 percent.

5. Guideline For Determining The Compliance Review Period Of A Facility That Changes Its Cost Reporting Period. A facility that changes its cost reporting period will have a compliance review period that, in accordance with the above table, is based on its new cost reporting period.

B. Types of Data Used to Determine Compliance with the Classification Criteria

1. Starting on July 1, 2004, the FI will use the verification procedures specified below in subsection C which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records" or subsection D which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population" to verify that an IRF has complied with the requirements specified above in §140.1.1B.

2. The verification procedure specified below in subsection C which is entitled "Verification of the Medical Condition Criterion Using the Inpatient

Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records" will only be used if the FI verifies that the IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population. The IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total inpatient population only if the IRF's total inpatient population is made up of 50 percent or more of Medicare Part A fee-for-service inpatients.

3. General Guideline Regarding Submission of a Listing of the IRF's Inpatients: In order to verify that the IRF's Medicare Part A fee-for-service inpatient population reflects what is the IRF's total patient population, the FI in writing will instruct the IRF to send to the FI, by a specific date, a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the CMS or the FI.

a. Exception to the General Guideline: The Secretary of Health and Human Services can declare a Public Health Emergency under section 319 of the Public Health Service Act or another appropriate statute, and the President can declare either a National Emergency under the National Emergencies Act or a Major Disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, or other appropriate law. In accordance with such declarations there may be occasions when in specific geographic areas for a definite time period the requirements stipulated in certain regulations or operational policies are waived. If applicable, in accordance with the waiver provisions, the IRF may be permitted to admit patients, referred to in this section as national emergency or disaster inpatients, who otherwise would be admitted to another inpatient setting. An IRF's national emergency or disaster inpatients will not be included as part of the IRF's total inpatient population when the IRF's compliance with the requirements specified in §140.1.1B is determined by the FI reading a sample of medical records. Therefore, when the IRF submits the list of hospital numbers stipulated above in section 140.1.4B3, the IRF will identify each national emergency or disaster inpatient by placing either the capital letter "E" or "D" after the hospital number the IRF assigned to its national emergency or disaster inpatients. Such identification will allow the FI to exclude these hospital numbers when the FI is determining the hospital numbers that the FI will use to select a sample of medical records. The IRF should appropriately document in the medical record sufficient information that identifies an inpatient as a national emergency or disaster inpatient.

4. For each inpatient represented by an inpatient hospital number on the list the IRF must include the payer the IRF can bill, or has billed, for the treatment and services the IRF has furnished to the inpatient. If an inpatient represented by an inpatient hospital number on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient represented by an inpatient hospital number on the list the IRF must include the IRF admission and discharge dates.

5. The FI will use the list of hospital numbers to determine what was the IRF's total inpatient population during a most recent, consecutive, and appropriate 12-

month period, as that time period is defined by CMS or the FI. The FI will then refer to the preceding "Table of Compliance Review Periods" and specifically the column labeled "Compliance Percentage Threshold Associated with a Compliance Review Period or Portions of the Compliance Review Period." The column illustrates that a cost reporting period may have a compliance review period which consists of one or two portions of time. After the FI has determined the IRF's total inpatient population during a 12-month period, if, as illustrated in the column, the compliance review period consists of only one portion of time then for that portion of time the FI will determine if at least 50 percent of the IRF's total inpatient population was covered under Medicare Part A fee-for-service.

- For example, the column labeled "Compliance Percentage Threshold Associated with a Compliance Review Period or Portions of the Compliance Review Period" illustrates that the cost reporting period which will start on 05/01/2007 has a compliance review period consisting of 12 months which is not divided into two portions of time. Therefore, the FI will determine if during the entire 12 months at least 50 percent of the IRF's total inpatient population was covered under Medicare Part A fee-for-service.

However if, as illustrated in the column, the compliance review period consists of two portions of time then for each portion of time the FI will separately determine if the Medicare Part A fee-for-service inpatient population was at least 50 percent of the entire inpatient population which the IRF treated during the same portion of time.

- For example, the column illustrates that the cost reporting period which will start on 07/01/2007 has a compliance review period that is divided into two portions of time with one portion of time being 4 months and the other 8 months. Therefore, the FI will consider each portion of time independently and determine if during the 4-month portion of time at least 50 percent of the IRF's total inpatient population was covered under Medicare Part A fee-for-service, and if during the 8-month portion of time at least 50 percent of the IRF's total inpatient population was covered under Medicare Part A fee-for-service.

A determination by the FI, in accordance with the preceding methodologies, that the IRF's Medicare Part A fee-for-service inpatient population was at least 50 percent of the matching entire inpatient population allows the FI to use the procedure stipulated below in subsection C, which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records," to presumptively determine if the IRF met the compliance threshold as specified above in §140.1.1B. However, in addition to the above process, the FI may, at the FI's discretion, sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service population is representative of the IRF's total inpatient population.

6. The FI will inform the RO if an IRF fails to send the list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the

FI, or if the list of inpatient hospital numbers does not include the payer or payers, and the admission and discharge dates that correspond with the inpatients whose hospital numbers are shown on the list. The RO will notify the IRF that failure to send the FI the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B.

C. Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records

1. In order to determine if a facility has presumptively complied with the criteria specified above in §140.1.1B, CMS will enable the FI to access CMS' IRF-PAI data records. Specifically, each FI will be allowed to access only the IRF-PAI information submitted by the IRFs that submit claims to that FI. In order to ensure that each FI will be allowed to access only the IRF-PAI information submitted by IRFs that submit claims to that FI, CMS obtained information from the FIs in order to create software that matched each FI to the IRFs that submit claims to it. However, over time an FI may have additional IRFs that submit claims to it, or may have IRFs that no longer submit claims to it. Therefore, in order to ensure that the software that matches an IRF to the FI to which the IRF submits claims is constantly updated by the 15th calendar day of each month, starting on February 15, 2005, the FI will electronically submit to the RO a table that has at least the following title and column headings:

FI List Of IRFs Of The FI (Then Specify The FI's Name)

The Name of An IRF That Submits Claims To This FI	The Provider Number Of This Same IRF That Submits Claims To This FI	The Cost Reporting Period Of This Same IRF	Is This Still The FI That The IRF Has Selected to Process Its Claims?	Is This IRF Submitting Claims To This FI For The First Time?

Each row of this table will specify the name of an IRF that submits claims to that FI, and in the other columns of that row the FI will specify the appropriate information associated with that specific IRF.

The RO then, after checking the FI's table for completeness and, as necessary, communicating with the FI to assure the information in the table is accurate, will forward the FI's table to the CMS contractor that maintains the IRF-PAI database. The CMS contractor that maintains the IRF-PAI database will then, if necessary, update the IRF-PAI database software the FI uses to presumptively verify compliance with the requirements specified in §140.1.1B. The FI must coordinate with their CMS RO to obtain privileges in order to obtain access to the software system that uses the IRF-PAI information to

determine presumptive compliance with the requirements specified above in §140.1.1B. The FI will provide the RO with user information from all the FI staff that are required to access the IRF-PAI data records.

2. When the FI accesses the IRF-PAI data records the FI will be able to generate a report using the IRF-PAI information which was previously submitted by the IRFs that submit claims to that FI. The software that the FI will use to generate the report will automatically use the specific ICD-9-CM and impairment group codes that are listed in this chapter in Appendix A to determine if a particular IRF is presumptively in compliance with the requirements specified above in §140.1.1B. Prior to generating a report that the FI will use to determine if the IRF has presumptively complied with the requirements specified above in §140.1.1B, the FI must allow the IRF to decide if the IRF prefers the data records that the FI will use to generate the report to be either the IRF-PAI data records of patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the compliance review period, or patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

Below are the sections of the report with example data.

State	Provider Number	Provider Name	Cost Report Period	Compliance Review Period
Any State	IRF Number	Best Rehab	08/01/2008	04/01/2007 To 03/31/2008

Initial 4 Month Review Period	Submitted Assessments	Eligible Assessments	Percent
04/01/2007 To 07/31/2007	100	60	60 %

Subsequent Review Period	Submitted Assessments	Eligible Assessments	Percent
08/01/2007 To 03/31/2008	200	130	65 %

The submitted assessments section identifies all the IRF-PAI data records that the IRF submitted to the IRF-PAI database during the dates specified in the initial 4 month review period or subsequent review period. The eligible assessments are the assessments submitted during the dates specified in the initial 4 month review period or subsequent

review period that, in accordance with the Appendix A instructions, matched one of the codes in Appendix A of this chapter. The cost reporting period shown is when the facility's next cost reporting period starts.

As illustrated in the above Table of Compliance Review Periods, the compliance review period sometimes is divided into portions of time. When the Table of Compliance Review Periods shows that the compliance review period is divided into two portions of time, then either of the following two methods may be used to ascertain whether the IRF met the compliance requirements described in §140.1.1B: (1) Each portion of the compliance review period meets a particular compliance percentage as specified in the above Table of Compliance Review Periods; or (2) A weighted average calculated from the compliance percentage associated with each portion of time of the compliance review period may be used to meet the compliance threshold requirements that are described more fully above in §140.1.1B. (How to calculate a weighted average is described in §140.1.4(c)(ii) and (e)(ii).)

The following examples illustrate when the compliance review period is divided into two portions of time, the two methods that the FI may use to determine if the IRF presumptively met the compliance requirements which are more fully described above in §140.1.1B. If the IRF presumptively meets the compliance requirements when the FI uses either method then it is determined that the IRF presumptively meets the compliance requirements described in §140.1.1B.

- An IRF with a cost reporting period starting on 08/01/07 has a compliance review period of 04/01/2007 to 03/31/2008 but that 12-month period is divided into two portions one of which is 04/01/2007 to 07/31/2007 and another of 08/01/2007 to 03/31/2008. As shown in the Table of Compliance Review Periods the portion of the compliance review period that is 04/01/2007 to 07/31/2007 had to meet a compliance threshold of 60 percent, and the 08/01/2007 to 03/31/2008 portion had to meet a compliance threshold of 65 percent. The data in the above report sections shows that 60 percent of the patients during 04/01/2007 to 07/31/2007 and 65 percent of the patients during 08/01/2007 to 03/31/2008 presumptively met the compliance percentage requirements specified above in §140.1.1B.

- Using the compliance percentage data for each portion of the compliance review period that is described in the above example, one weighted average compliance percentage for the entire 12-month compliance review period may be calculated. The weighted average compliance percentage for the entire 12-month compliance review period is 63.4 percent which is rounded to 63 percent. Using the weighted average method to determine one compliance percentage means that the example data from the presumptive report would result in the IRF not meeting the compliance threshold of 65 percent for the cost reporting period that will start on 08/01/07.

As shown in the Table of Compliance Review Periods the cost reporting period of an IRF can result in the compliance review period not being divided into two portions. When the

compliance review period is not divided into two portions the FI must use the data from the report sections to perform additional calculations in order to determine the percentage of patients who presumptively met the compliance percentage requirements specified above in §140.1.1B.

- For example, an IRF with a cost reporting period starting on 08/01/06 would have a compliance review period of 04/01/2006 to 03/31/2007 and that 12-month period is not divided into two portions. To determine the compliance percentage the IRF presumptively attained during the compliance review period of 04/01/2006 to 03/31/2007, the FI will generate a report with sections as illustrated below. The data shown in the following presumptive report sections allow this example to be used to specify how the FI will determine the compliance percentage.

State	Provider Number	Provider Name	Cost Report Period	Compliance Review Period
Any State	IRF Number	Excellent Rehab	08/01/2007	04/01/2006 To 03/31/2007

Initial 4 Month Review Period	Submitted Assessments	Eligible Assessments	Percent
04/01/2006 To 07/31/2006	114	57	50 %

Subsequent Review Period	Submitted Assessments	Eligible Assessments	Percent
08/01/2006 To 03/31/2007	200	140	70 %

The format of this report is similar to the format of the report that the FI will generate if the compliance review is divided into two portions of time. However, because in this example the compliance review period is not divided into two portions of time the FI disregards the percentages shown in the report sections and instead performs additional calculations to determine the compliance percentage. When the compliance review period is not divided into two portions the following two methods shows how the data from the above report sections is used to calculate the compliance percentage. Each method results in the same percentage.

Method 1:

In this example, the total number of patients in the entire compliance review period is 314.

The report shows that of the submitted assessments during a 4-month period 57 of 114 patients presumptively met at least one the conditions listed above in §140.1.1C.

The report shows that of the submitted assessments during an 8-month period 140 of 200 patients presumptively met at least one of the conditions listed above in §140.1.1C.

57/114=0.5000 140/200=0.7000

114/314=0.363 200/314=0.637

0.5000 X 0.363=0.1815
0.7000 X 0.637=0.4459

0.1815 + 0.4459=0.6274 and this is rounded to 63 percent.

Method 2:

In this example, the total number of patients in the entire compliance review period is 314.

The report shows that of the submitted assessments during a 4-month period 57 of 114 patients presumptively met at least one the conditions listed above in §140.1.1C.

The report shows that of the submitted assessments during an 8-month period 140 of 200 patients presumptively met at least one of the conditions listed above in §140.1.1C.

57 + 140 = 197

197/314 = 0.627388 and this is rounded to 63 percent.

In this example, the cost reporting period started on 08/01/06 and during the compliance review period of 04/01/2006 to 03/31/2007 the provider presumptively attained a compliance percentage of 63 percent. The compliance threshold that the provider had to meet during the compliance review period was 60 percent.

3. An IRF whose inpatient Medicare Part A fee-for-service population reflects its total inpatient population and that, according to the report generated using the procedure specified above in subsection C2, is verified by the FI to have met the requirements specified above in §140.1.1B will be presumed by the FI as having a total inpatient population that meets the requirements specified above in §140.1.1B. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B, the RO and FI still have the discretion to instruct the IRF to send to the RO or FI specific sections of the medical records of a random sample of inpatients, or specific sections of the medical records of inpatients identified by other means by CMS or the FI.

4. The CMS Central Office and RO staff have the discretion to require that each FI, on a quarterly or more frequent basis, submit a report that shows the status of the level of compliance by a FI's IRFs with the requirements specified above in §140.1.1B.

5. Appendix A to this chapter lists the ICD-9-CM and IRF-PAI impairment group codes, that will be used to determine presumptive compliance with the requirements specified above in §140.1.1B.

D. Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population

1. The FI must use the IRF's total inpatient population to verify that the IRF has met the requirements specified above in §140.1.1B if: (i) the IRF's Medicare population does not reflect its total patient population; or (ii) if the FI is unable to generate a valid report using the IRF-PAI database methodology specified previously; or (iii) if the FI generates a report which demonstrates that the IRF has not met the requirements specified above in §140.1.1B. In the case where the Medicare Part A fee-for-service inpatients comprise less than 50 percent of the IRF inpatient population, or the FI otherwise determines that the Medicare Part A fee-for-service inpatients are not representative of the overall IRF inpatient population, or the FI is unable to generate a valid report using the IRF-PAI methodology, the presumptive determination is that the IRF did not meet the requirements specified above in §140.1.1B.

2. As previously stated above, the FI will instruct the IRF to send the FI a list showing the hospital number the IRF assigned to each inpatient that the IRF admitted during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI. The list of inpatient hospital numbers must include the payer(s) and admission and discharge dates that correspond with the inpatients whose hospital numbers are shown on the list. The FI will then use generally accepted statistical sampling techniques to determine from the list what is a statistically appropriate random sample number of inpatients.

When the compliance review period is divided into two portions of time, the total inpatient population during each portion of time is separately determined and a sample will then be separately selected from the total inpatient population of each portion of time. However, regardless if the compliance review period is or is not divided into two portions of time, the use of generally recognized statistical sampling principles may result in a determination that it would be inappropriate to use a sample to determine the compliance percentage or percentages attained by the facility. If a determination is made that it is inappropriate to use statistical sampling then the entire inpatient population will be used to determine the compliance percentage.

Prior to selecting the sample number of inpatients, the FI must allow the IRF to decide if the IRF wants the sample to contain <u>either</u> the patients who were admitted during the IRF's compliance review period regardless if these patients were discharged during the

compliance review period, or the patients discharged during the IRF's compliance review period regardless if these patients were admitted during the compliance review period.

If the confidence level of the statistic derived from the sample is not at least 95 percent then the FI will adjust the sample or if necessary use the entire inpatient population to determine if the IRF meets the requirements as specified above in §140.1.1B. In addition, if an IRF during a most recent, consecutive, and appropriate 12-month period, as that time period is defined by the FI, had a total inpatient population of 100 inpatients or less, the FI will use the total inpatient population that consists of Medicare and non-Medicare inpatients as the random sample size.

The FI will instruct the IRF to send it copies of specific sections of the medical records of inpatients, using the random sample of inpatients selected from the list to identify which inpatients are selected. The FI has the discretion to decide which specific sections of the medical records of the inpatients to obtain, provided that the requested medical record sections contain enough information to allow the FI's reviewers to determine what was the inpatient's medical condition(s) that the IRF treated. In addition to submitting to the FI the sections of the medical records of the random sample inpatients specified by the FI, the IRF has the discretion to send the FI other clinical information regarding these same inpatients. The admission and discharge dates as specified in the medical record sections obtained by the FI must be for the most recent, consecutive, and appropriate 12-month period as defined by CMS or the FI.

3. The FI will examine the medical records sections obtained and determine if the IRF meets the requirements as specified above in §140.1.1B. When determining if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the FI may use the ICD-9-CM and impairment group codes specified below in Appendix A to this chapter as guidance, or make that determination based upon only the medical judgment of its reviewer(s), or use a combination of both methods. In general, when the FI is using a sample of medical records to determine compliance by the IRF with the requirements in §140.1.1B, the FI always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the presumptive test methodology described above. In other words, the compliance percentage that is determined by the FI obtaining information from a sample of medical records will supersede the compliance percentage that was determined for the same compliance review period by the FI using the presumptive method. In order to promote a compliance percentage determination process that is similar for all IRFs, the FI must have written policies that describe the reasons for the FI using a random sample of medical records to determine the compliance percentage when the FI has already determined by the presumptive method that the IRF met the compliance threshold.

4. The FI will inform the RO if an IRF fails to provide information in accordance with the requirements specified above in subsection D2. The RO will notify the IRF that failure to provide the FI with the information in accordance with the

requirements specified above in subsection D2 will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B.

E. By the 15th day of the each month, the FI responsible for determining the compliance percentage an IRF achieved in accordance with either of the methods specified above in §§140.1.4C or 140.1.4D will submit a report via e-mail. Instructions regarding the format of the report, how to complete the report, and where to send it are specified at the following Web site:

http://www.cms.hhs.gov/InpatientRehabFacPPS/03_Criteria.asp

F. If a rehabilitation hospital is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the criteria specified above in §140.1.1E-H will be presumed to have been met. However, in all instances the FI must verify that the requirements specified above in §140.1.1B were met. In addition, the State Agency is required to verify that the rehabilitation hospital has a Director of Rehabilitation who meets the requirements specified above in §140.1.1I.

G. If a rehabilitation hospital is not currently accredited by CARF then the State Agency will determine whether the criteria specified above in §140.1.1E-I were met. In addition, in all instances the FI must verify that the requirements specified above in §140.1.1B were met.

H. If a rehabilitation unit is currently accredited by CARF the criteria specified above in §140.1.1E-H will be presumed to be met. However, in all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, have been met. Also, the State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

I. If a rehabilitation unit is not currently accredited by CARF then the State Agency is required to determine if the criteria specified above in §140.1.1E-H has been met. In all instances the FI must verify that the criteria specified above in §140.1.3N-O were met. In addition, the FI must verify that the accounting criteria specified above in §140.1.3G-K, and that the criteria specified below in §140.1.6 have been met. The State Agency is required to verify that the rehabilitation unit meets the requirements for a Director of Rehabilitation as specified above in §140.1.3Q.

140.1.5 - Hospitals That Have Not Previously Participated In Medicare
(Rev. 221, 06-25-04)

A hospital that has not previously participated in the Medicare program, and seeks exclusion from the acute care hospital PPS for the entire hospital, may provide a written certification that the inpatient population the hospital intends to serve will meet the requirement in §140.1.1B above, instead of showing that it has treated such a population during its most recent, consecutive, and appropriate 12-month time period (as defined by

CMS or the FI). The written certification is effective for the first full 12-month cost reporting period that occurs after the hospital becomes a Medicare participating hospital, and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's first regular 12-month cost reporting period of Medicare participation.

For purposes of §140.1.5, a hospital that has undergone a change of ownership or leasing is considered to have not participated previously in the Medicare program.

140.1.6 - Changes In The Status Of An Inpatient Rehabilitation Unit
(Rev. 221, 06-25-04)

The status of an inpatient rehabilitation unit may be changed from not excluded from the acute care hospital PPS, to excluded from the acute care hospital PPS, only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the acute care hospital PPS before the start of a hospital's next cost reporting period.

The status of an inpatient rehabilitation unit may be changed from excluded from the acute care hospital PPS to not excluded from the acute care hospital PPS at any time during a cost reporting period, but only if the hospital notifies the FI and the RO in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period, must remain in effect for the rest of that cost reporting period.

140.1.7 - New And Converted Inpatient Rehabilitation Facility Units
(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

A. New Unit: A hospital unit is considered a new IRF unit if the hospital:

1. Has not previously sought exclusion from the acute care hospital PPS for any rehabilitation unit; and

2. Has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

B. A hospital that seeks to have a new unit classified as an IRF must provide a written certification that the inpatient population the hospital intends the unit to serve, meets the requirements specified above in §140.1.1B, instead of showing that the unit has treated such an inpatient population during the hospital's most recent cost reporting period. The written certification is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care. The written certification also is effective for any cost reporting period of not less than 1 month, and not more than 11 months occurring

between the dates the hospital began participating in Medicare, and the start of the hospital's regular 12-month cost reporting period.

C. A hospital that has undergone a change of ownership or leasing as defined in the regulations is not considered to have participated previously in the Medicare program.

D. Converted unit--A hospital unit is considered a converted IRF unit if it does not qualify as a new IRF unit.

1. In general, a converted unit seeking classification as an IRF unit must have treated, during the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI), an inpatient population meeting the requirements specified above in §140.1.1B, except as specified below in paragraph 2.

2. If the most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI) used to verify that the converted unit seeking classification as an IRF unit includes a time period prior to July 1, 2004, then the following procedure will be used:

   a. For the part of the 12-month time period (as defined by CMS or the FI) that is after July 1, 2004, the unit's inpatient population must have met the requirements specified above in §140.1.1B.

   b. For the part of the 12-month time period (as defined by CMS or the FI) that is before July 1, 2004, the unit's inpatient population must have met 50 percent of the following medical conditions:

      (1) Stroke;

      (2) Spinal cord injury;

      (3) Congenital deformity

      (4) Amputation;

      (5) Major multiple trauma;

      (6) Fracture of femur (hip fracture);

      (7) Brain injury;

      (8) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease;

      (9) Burns; and

(10) Polyarthritis.

c. For the part of the conversion compliance time period that is after July 1, 2004, the FI will use the total inpatient population verification method specified above in §140.1.4D, "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population," to determine what percentage of the unit's inpatient population met the requirements specified above in §140.1.1B. In other words, the post July 1, 2004, data used to verify that the requirements specified above in §140.1.1B were met, will consist of data only from July 1, 2004, and the time period afterward, until when the time period used to determine compliance as a converted unit ends.

d. For the part of the conversion compliance time period that is before July 1, 2004, the FI will use the total inpatient population verification method specified above in §140.1.4D, "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population," to determine what percentage of the unit's inpatient population met one, or more, of the 10 medical conditions specified above in paragraph (b) of this section. In other words, the pre July 1, 2004, data used to verify what percentage of patients matched one, or more, of the 10 medical conditions specified above in paragraph (b) of this section, would consist of data only from before July 1, 2004, and prior months as far back as the first day that started the time period used to determine compliance. For pre July 1, 2004 data, the FI staff will use its medical expertise to evaluate if a case meets the term "polyarthritis."

e. The pre and post July 1, 2004, percentages obtained using the methodology specified above in paragraphs (c) and (d) of this section will be combined, using weighted average techniques, to determine if the converted unit's total inpatient population met a compliance threshold percentage of 50 percent or more.

E. Expansion of an IRF unit--(1) New bed capacity. The beds that a hospital seeks to add to its IRF unit are considered new beds only if:

1. The hospital's State licensed and Medicare certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its IRF unit, or at any time after the start of the preceding cost reporting period; and

2. The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the IRF unit.

3. If a hospital expands its IRF unit by adding beds, the medical conditions of the patients treated in the added beds during the most recent, consecutive, and

appropriate 12-month time period (as defined by CMS or the FI) must be taken into account in determining whether the requirements specified above in §140.1.3N were met.

4. A hospital that has an IRF unit may obtain approval to add bed capacity under State licensure and under its approved Medicare provider agreement, and may seek to add new beds to its existing excluded unit for the first 12-month cost reporting period during which the new beds are used to provide inpatient care. The hospital must provide a written certification that the inpatient population the new beds are intended to serve, meets the requirements specified above in §140.1.1B, instead of showing that those beds were used to treat such an inpatient population during the unit's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI).

F. Conversion of Existing Bed Capacity

Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity as specified above in paragraph E(1).

A hospital may increase the size of its IRF unit through conversion of existing bed capacity only if it shows that, for the hospital's most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the FI), the beds have been used to treat an inpatient population meeting the requirements specified above in §140.1.1B.

G. Retroactive Adjustments for Certain IRF Units

For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new IRF unit excluded from the acute care hospital PPS for a cost reporting period as specified above in paragraphs A and B of this section, or expands an existing IRF unit as specified above in paragraph E of this section, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period do not meet the requirements specified above in §140.1.1B, CMS adjusts payments to the hospital retroactively in accordance with the procedure specified below in §140.1.8.

140.1.8 - Retroactive Adjustments For Provisionally Excluded Inpatient Rehabilitation Facilities Or Beds

(Rev. 221, 06-25-04)

A. If a hospital, hospital unit, or group of beds is paid under the IRF PPS for a cost reporting period based on a written certification that it will meet one of the requirements specified above in §140.1.1B, but does not actually meet the requirement for that cost reporting period, CMS adjusts its payments to the hospital retroactively in accordance with paragraph C below.

B. In the case of a unit to which new beds have been added the requirement in §140.1.1B above is applied to the entire unit, including both new and added beds. If the entire unit is

able to meet the requirement, the previously existing unit and the added beds are presumed to meet the requirement separately and no payment adjustment as specified below in paragraph C is made. If the unit as a whole does not meet the requirement specified above in §140.1.1B, the hospital must furnish the FI or the State Agency, as specified by the RO, the information needed to determine whether the requirement specified in §140.1.1B above was met by the established portion of the unit (that is, the previously existing unit) and by the newly added beds, considered separately. If the established portion of the unit did not meet the requirement, no retroactive payment adjustment is made for services in the established portion of the unit, but that portion is not classified as an IRF for the following cost reporting period. If the added beds met the requirement specified above in §140.1.1B, no retroactive payment adjustment is made for the added beds and those beds are eligible to be included as part of the unit's classification as an IRF for the following cost reporting period. If the added beds did not meet the requirement, the FI adjusts its payment to the unit retroactively in accordance with paragraph C below and the added beds are not included as part of the unit classified as an IRF for the following cost reporting period.

If the hospital does not have the records needed to discriminate between the performance of the previously existing unit, and that of the added beds or for other reasons does not furnish the information requested by the FI or State Agency, neither the previously existing unit nor the added beds are classified as an IRF for the following cost reporting period. In that case, the FI adjusts its payment to the entire unit retroactively in accordance with paragraph C below.

C. The FI adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion, and the amount that would have been paid if the hospital, unit, or beds had not been excluded from the PPS. The FI then takes action to recover the resulting overpayment, or corrects the underpayment to the hospital.

140.2 - Payment Provisions Under IRF PPS
(Rev. 1, 10-01-03)

A-03-008

Section 1886 of the BBA provides the basis for establishing the Federal payment rates applied under PPS to IRFs. The PPS incorporates per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system.

IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre-admission services, but are subject to the 1-day payment window (24-hour rule) for pre-admission services.

Beneficiary liability will operate the same as under the current Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system. Even if Medicare payments are

below cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

140.2.1 - Payment Adjustment Factors and Rates
(Rev. 1, 10-01-03)

The BBA sets forth the methodology for establishing the payment rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and other factors the Secretary deems necessary to ensure that payment most accurately reflects cost.

The BBA specifies that payments during fiscal years 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. As a result of the implementation of BIPA, a change has been made to eliminate the payment amount of 98 percent of the FY 2002 expenditures. Under §305 of the BIPA 2000, §1886(j)(3)(b) of the Act is amended to increase the amount of payment to 100 percent of FY 2002 expenditures.

For the initial period of PPS, beginning on or after January 1, 2002, all payment rates and associated rules were published in the "Federal Register" on August 7, 2001. For each succeeding fiscal year, the rates will be published in the "Federal Register" on or before August 1 of the year preceding the affected fiscal year.

140.2.2 - Case-Mix Groups
(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities were used to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. In addition to the first two digits of the CMG indicating what is the RIC, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age improves the explanatory power of the CMGs if some groups are split based on this variable. Lastly, comorbidites were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

140.2.3 - Case-Level Adjustments
(Rev. 1, 10-01-03)

Payment is based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. For case level adjustments, more than one case level adjustment may apply to the same case. For ease of understanding, the case level discussion is presented below in the same order that is used to assess whether or not they apply. For example, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for interrupted stay cases and the payment will be based on the initial assessment. For example, if a Medicare beneficiary is discharged on February 1, 2001, and is readmitted on February 3, the case would be considered an interrupted stay and only one CMG payment will be made based on the initial assessment. However, if the Medicare beneficiary was readmitted on February 4, then it would not be considered an interrupted stay. A separate DRG payment will not be made to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, a DRG payment can be made if the beneficiary does not return to the same IRF on the same day as they were discharged. If a case is determined to be an interrupted stay, other adjustments may apply to this payment amount. For example, the case still may meet the definition of a transfer case described below.

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Further cases that expire with a length of stay of 3 days or less, will also be classified to CMG 5001.

Separate CMGs will also be made for cases that expire with a length of stay greater than 3 days. To improve the explanatory power of the groups, four additional CMGs were created to account for cases that expire. CMG 5101 is used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs

07, 08, and 09 and the length of the stay is greater than 3 days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

140.2.4 - Facility Level Adjustments

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facility's located in rural areas, an adjustment for treating low-income patients and an adjustment for teaching facilities. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can be determined to qualify for these additional payments only after all other facility-level adjustments are computed. Thus, for ease of understanding, the discussion of these facility-level and outlier adjustments are presented in the same order that is used to assess their applicability.

140.2.4.1 - Area Wage Adjustments

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

To adjust payments for area wage differences, CMS first identifies the labor-related portion of the prospective payment rates which is published annually in the **Federal Register**. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. CMS uses the inpatient acute care hospital wage data to compute the wage indices on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under §§1886(d)(8) or (d)(10) of the Act and without applying the “rural floor” under §4410 of the BBA. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare part B, because these services are not covered under the IRF PPS. The wage index that applies to the IRF PPS payment rates excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists. For IRF PPS discharges occurring before October 1, 2005, IRFs are divided into labor market areas where urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget.

For IRF PPS discharges occurring on or after October 1, 2005, the IRF PPS adopts new labor market area definitions based upon the new statistical area definitions issued by the Office of Management and Budget (OMB) in OMB Bulletin No. 03-04, June 6, 2003. OMB Bulletin No. 03-04 includes new definitions of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, more commonly referred to as Core-Based Statistical Areas (CBSAs). CBSA-based designations reflect the most

recent available geographic classifications and more accurately reflect current labor markets. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs. CMS uses the county-based areas for all MSAs in the Nation, including those in New England. Adopting county-based labor market areas for the entire country creates consistency and stability in the Medicare payment program because all of the labor market areas, including New England, are defined using the same system (that is, counties), rather than different systems in different areas of the country, and minimizes program complexity. CMS uses the Metropolitan Divisions where applicable under the new CBSA-based labor market area definitions to determine urban areas. Micropolitan Areas are treated as rural labor market areas under the IRF PPS. To calculate the statewide rural wage index for each State, CMS combines all of the counties in a State outside of a designated urban area, including Micropolitan Areas. The rural and Micropolitan IRFs are assigned a statewide rural wage index for the state in which the IRF is located. The wage indices applicable to IRF PPS discharges occurring on or after October 1, 2005, are published in the annually in the **Federal Register**.

A one-year transition policy providing for a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index that are both based on the FY 2001 hospital wage data) will apply to all IRFs. This transition policy is effective for discharges occurring on or after October 1, 2005 and on or before September 30, 2006. The transition will mitigate the negative impact for IRFs that experience a decrease in the wage index and allow one year for all IRFs to transition from the MSA-based wage index to the CBSA-based wage index.

140.2.4.2 - Rural Adjustment

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-MSA area.

For FY 2006 and FY 2007, a hold harmless policy applies to IRFs that meet the definition of rural in FY 2005 in §412.602 and become urban under the FY 2006 CBSA-based designations. The IRFs that meet the criteria described in the previous sentence will qualify for an adjustment to their payments in FY 2006 and FY 2007 equal to some portion of the 19.14 percent rural adjustment effective in FY 2005. This adjustment is in addition to the one-year blended wage index described above for discharges occurring on or after October 1, 2005 and on or before September 30, 2006.

140.2.4.3 – Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev. 1479; Issued: 03-14-08; Effective: 04-01-08; Implementation: 04-07-08)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate a file will be updated annually (usually each October/November).

Patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111), which includes both Condition Code 04 and a default CMG code of A9999, to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for Fiscal Year 2007 and beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

The SSI/Medicare beneficiary data for IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The files are located at the following CMS Web site address:

http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the FI settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The FI uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation), is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any

services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.

140.2.4.4 - Outliers

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Additional payments are made for any discharge if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount. The estimated cost of the case is calculated by multiplying the IRF's overall cost-to-charge ratio (CCR), obtained from the latest settled cost report (subject to a ceiling), by the Medicare allowable covered charge. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments are added to the adjusted payment amount. The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above). The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the **Federal Register**.

A national CCR based on the facility location of either rural or urban is applied in the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.

- IRFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean.

- Other IRFs for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital CCR (or both) are not available.

For new facilities, the national ratio will be used until the IRF's actual CCR can be computed using the first tentative settled or final settled cost report data , which will then be used for the subsequent cost report periods. The national urban and rural CCRs for IRFs are set forth annually in the **Federal Register**.

140.2.4.5 - Teaching Status Adjustment

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The teaching status adjustment is a facility level adjustment made to the Federal per discharge base rate to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education. The adjustment is made on a claim basis as an interim payment, with final payment in full for the cost reporting period made through the cost report. Any difference between the interim payments and the actual teaching status adjustment amount computed in the cost report are adjusted through lump sum payments/recoupments when the cost report is filed and later settled. The adjustment is based on the IRF's "teaching variable," which is the ratio of the number of FTE residents training in the IRF (subject to the FTE resident cap described below) to the IRF's average daily census (ADC).

140.2.4.5.1 - FTE Resident Cap

(Rev. 1137, Issued: 12-22-06, Effective: 10-01-05, Implementation: 01-22-07)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, not the number of residents teaching institutions can hire or train. The FTE resident cap is identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. The cap is the number of FTE residents that trained in the IRF during a "base year."

An IRF's FTE resident cap is determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. IRFs that first began training residents after November 15, 2004 will initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

For other types of Medicare providers (including long-term care hospitals) that have been training residents and are currently converting to IRFs, the fiscal intermediary will determine an FTE resident cap for purposes of the IRF teaching status adjustment, applicable beginning with the new IRF's payments under the IRF PPS based on the FTE count of residents during the predecessor facility's most recent cost reporting period ending on or before November 15, 2004. If the predecessor facility did not begin training residents until after November 15, 2004, the facility would initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in §413.79(1)), may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in §412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

Once established, the FTE resident cap for the teaching status adjustment for the new IRF will be subject to the same rules and adjustments as any IRF's FTE resident cap. We note that we will monitor this policy closely to ensure that it is not being inappropriately manipulated.

IRFs are not permitted to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents floating through the rehabilitation hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IRF (for example, a resident on a full-time, 3-month rotation to the IRF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS IME adjustment is allowed to be counted for purposes of the teaching status adjustment for the IRF PPS.

The denominator used to calculate the teaching status adjustment under the IRF PPS is the IRF's average daily census (ADC) from the current cost reporting period. If a rehabilitation hospital or unit has more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If a rehabilitation hospital or unit were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility hires and trains).

140.2.5 - Phase-In Implementation
(Rev. 1, 10-01-03)

Under the BBA, the Federal fiscal year in which a facility's cost reporting period begins, determines which transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during Federal fiscal year 2001. The second transition period percentages are applicable to cost reporting periods beginning during Federal fiscal year 2002, that is, periods beginning on or after October 1, 2001, and before October 1, 2002. For cost reporting periods beginning during Federal

fiscal year 2003 and after, payment is based on 100 percent of the adjusted Federal prospective payment.

Since CMS is implementing the IRF PPS for discharges that occur during the IRF's cost reporting period that begins on or after January 1, 2002, IRFs are phased directly into the second transition period, where payment will be based on 66 2/3 percent of the PPS payment and 33 1/3 percent of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its **entire** cost reporting period beginning prior to January 1, 2002.

In addition, §305 of the BIPA 2000 states facilities may elect to be paid 100 percent PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their FI no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the Medicare FI for the facility. The FI must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

140.2.6 - Outlier Payments: Cost-to-Charge Ratios

(Rev. 1585, Issued: 09-05-08, Effective: 10-01-08, Implementation: 10-06-08)

This section describes the appropriate data sources for computing an overall Medicare facility-specific cost-to-charge ratio (CCR) for the purpose of determining outlier payments under the IRF PPS. For discharges beginning on or after October 1, 2003, FIs will use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period). FIs will use the cost report and the associated data in determining a facility's overall Medicare CCR specific to freestanding IRFs of for IRFs that are distinct part units of acute care hospitals.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare CCR appears to be substantially out-of-line with similar facilities, the FI should ensure that the underlying costs and charges are properly reported.

Effective October 1, 2003, an IRF will be assigned the appropriate national average CCR that falls above three standard deviations from the national mean (upper threshold). CMS will not use a lower threshold and an IRF will receive their actual CCR, no matter how low their ratio falls.

For discharges occurring on or after October 1, 2003 and before October 1, 2004, the upper threshold is 1.461 and the national CCRs are 0.597 for rural IRFs and 0.554 for urban IRFs. For discharges occurring on or after October 1, 2004, and before October 1, 2005, the upper threshold is 1.461, and the national CCR are 0.636 for rural IRFs and 0.531 for urban IRFs. For discharges occurring on or after October 1, 2005, refer to the appropriate FY Recurring Update Change Request.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of the inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swingbed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file contains a field for the operating CCR (Field 25; file position 102-105) and for the capital CCR (Field 42; file position 203-206). Because the CCR computed for the IRF PPS includes routine, ancillary, and capital costs, the CCR for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

A Calculating Medicare CCRs for Freestanding IRFs

For freestanding IRFs, Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). For freestanding IRFs, total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col., line 101). Divide the Medicare costs by the Medicare charges to compute the CCR.

B - Calculating Medicare CCRs for IRF Distinct Part Units

For IRF distinct part units, total Medicare inpatient routine and ancillary charges will be obtained from the PS&R report associated with the latest settled cost report. [If PS&R data is not available, estimate Medicare routine charges by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.] To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101). Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

C - Calculating Medicare CCRs for New IRFs

As stated in the final rule, new facilities may receive outlier payments even though they

will not have the historical cost report information needed to compute the estimated cost that determines if a case is an outlier. Therefore, a national CCR based on the facility location of either urban or rural will be used. Specifically, for FY 2005, CMS has estimated a national CCR of 0.636 for rural IRFs and 0.531 for urban IRFs. Unless otherwise notified, FIs use these national ratios until the facility's actual CCR can be computed using the first tentative settled or final settled cost report data which will then be used for the subsequent cost report period.

The CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the national CCRs applicable to IRFs in each year's annual notice of prospective payment rates published in the **Federal Register**.

D - Use of More Recent Data for Determining CCRs

In order to arrive at a CCR to be used in the PSF based on tentative settlement data, the intermediary should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCR to determine if they had an impact on the CCR. If these tentative settlement adjustments have no impact on the CCR, or if no adjustments were made, the tentative settled CCR will equal the CCR from the IRF's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCR, the intermediary should compute a new CCR 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 the CCR for all IRFs for discharges on or after October 1, 2003, FIs should continue to update an IRF's CCR 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 IRF PPS claims processed after the update.

The CMS may direct FIs to use an alternative CCR to the CCR 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, the FI should contact CMS to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IRF 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 regional office must approve any such request after

evaluation by the fiscal intermediary of the evidence presented by the IRF.

E - Reconciling Outlier Payments for IRFs

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, FI s are to reconcile IRF PPS outlier payments at the time of cost report final settlement if:

1) Actual CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2) Outlier payments exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which outlier payments were made in a cost reporting period. These criteria for the IRF PPS will be reevaluated periodically to assess whether they should be revised.

In the event that these criteria do not identify facilities that are being overpaid (or underpaid) significantly for outliers, then, based on an analysis of the facility's most recent cost and charge data that indicates that the CCR for those facilities are significantly inaccurate, FIs also have the administrative discretion to reconcile cost reports of those IRFs. However, FIs must seek approval from their regional office in the event they intend to reconcile outlier payments for an IRF that does not meet the above-specified criteria. The CMS will be issuing separate instructions detailing procedures to follow regarding this reconciliation process and the application of the adjustment for the time value of money.

F - Notification to Facilities Under the IRF PPS

The FIs are to notify a facility 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.

140.3 - Billing Requirements Under IRF PPS

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS

(HIPPS) Rate Code on Form 1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill 11X) to their FIs. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Discharge Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

Covered Charges should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim

bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- IRFs are required to report the number of units based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

140.3.1 - Shared Systems and CWF Edits

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

- To insure that revenue code 0024 is not reported more than once on bill type 11X;

- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.

- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);

- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);

- To reject subsequent claims with the same PPS provider on the same day (CWF);

- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);

    - CWF accepts the incoming claim and sends an informational unsolicited response to the FI on the history claim if the patient status code does not match the incoming provider number

    - The FI cancels the history claim to the provider

- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);

- CWF rejects the incoming claim if the patient status code does not match the provider number;

- FI returns the incoming claim to the provider for correction of the patient status code.

- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.

- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;

- Units entered on the 0024 must be accepted, but are not required.

- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,

- To insure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay $\leq$ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/

- The accommodation revenue code 018x (leave of absence) will continue to be used in the current manner including the appropriate occurrence span code 74 and date range.

140.3.2 - IRF PPS Pricer Software

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The CMS has developed an IRF Pricer Program that calculates the Medicare payment rate. Pricer will use a variety of inputs listed below to calculate the payment rate.

A. Inputs to Pricer

- Provider Specific File data (see section 20.2.3.1 and Addendum of this chapter for required elements)

- Bill Data includes:

    - Patient Status:

    - Payment Modification Flag (if condition code is 66, set flag "Y" otherwise use "N.");

    - Covered Charges;

    - Discharge Date;

    - HIPPS/CMG Rate Code;

    - Length of Stay (LOS);

    - Covered Days;

- Lifetime Reserve Days (LTR)

B. Data Returned From Pricer

Pricer returns the following information:

- PPS Return Code
- MSA /CBSA (effective October 1, 2005)
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-Income Payment (LIP) Amount
- Teaching Amount (effective October 1, 2005)
- LOS
- Regular Days Used
- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold

- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

The Pricer is available electronically to the Shared Systems.

140.3.3 - Remittance Advices
(Rev. 1, 10-01-03)

A new remittance advice remark code is used to notify an IRF when the CMG code was changed: N100 code corrected during adjudication.

The FIs must notify IRF facilities of the new code and its definition prior to initial use. Existing reason and remark codes are used in remittance advice transactions to explain other adjustments made to the claim during adjudication.

Providers receiving version 3051.4A.01 of the Electronic Remittance Advice (ERA) will receive the CMG code under which payment is made in the service level procedure code field, identified with qualifier HC. If the CMG is modified during adjudication, the paid under CMG (rather than the submitted CMG), will be reported at the service level. Providers receiving version 4010 of the ERA will have the CMG reported in the same location, but with qualifier ZZ. Providers that receive earlier versions of the ERA, or who receive only paper RAs, will not receive service level details.

Existing Medicare Summary Notices and Notices of Utilization for beneficiaries are appropriate for IRF PPS claims.

140.3.4 - Payment Adjustment for Late Transmission of Patient Assessment Data
(Rev. 619, Issued: 07-29-05, Effective: 01-01-06, Implementation: 01-03-06)

In accordance with the regulations, Medicare (Part A fee-for-service) patient assessment data, collected through the inpatient rehabilitation facility patient assessment instrument (IRF-PAI), must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge. Under 412.614(d)(2), if the actual transmission date is later than 10 calendar days from the mandated transmission date, the patient assessment data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

A. How the penalty is determined. In accordance with the regulations, inpatient rehabilitation facility-patient assessment instrument (IRF-PAI) data collected on a Medicare Part A fee-for-service inpatient must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the inpatient's discharge. Under the IRF prospective payment system regulations, if the actual transmission date is later than 10 calendar days from the mandated transmission date, the IRF-PAI data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

B. Claim coding requirement: When Medicare Part A fee-for-service is the primary payer revenue code line 0024, Field Locator 45 (or electronic equivalent), Service Date, when entered by the provider or CMS adjustment process, will equal the date on which the final assessment was transmitted to the CMS National Assessment Collection Database. This field is mandatory on all discharge IRF PPS claims, whether the IRF-PAI was transmitted late or not. Transmission of the IRF-PAI data record 28 or more calendar days after the discharge date specified on the claim will result in the claim incurring the 25 percent late IRF-PAI data transmission penalty. If the provider does not complete this field accurately and the IRF-PAI data record is transmitted 28 calendar days or more from the date of discharge, CMS will utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment. Complete details of the CMS post-payment review process will be determined at a later date.

The following modifications were made to the IRF Pricer to account for the payment adjustment:

Under the inputs to Pricer, the "payment modification flag" has been changed to "special payment indicator." This is an alpha-numeric field with valid entries of 0 - 3 currently.

The shared systems will set the payment modification flag to:

1 = If the claim has Condition Code 66 entered

2 = If the IRF-PAI data record transmission date present on the revenue code line with 0024 is 28 calendar days or more from the date of discharge on this claim

3 = Both 1 and 2 above apply, or

0 = Default value

Under Pricer outputs, Pricer returns a "penalty amount" field. When applicable, the amount in this field will equal 25 percent of the total payment amount computed by Pricer. The total payment amount field will be then be reduced by the penalty amount so that the final total payment amount output by Pricer will be 75 percent of the total payment amount due the provider.

Return codes 10 - 17 identify claims where there was a penalty and mirror return codes 00 – 07.

C. Waiver of the penalty. Under the regulations CMS may waive the penalty specified above in section A. The following describes when the penalty may be waived:

(1) When CMS or the FI determines that a claim the IRF submitted should not be subject to the payment penalty specified above in section A because CMS or the FI has determined that due to an extraordinary situation the IRF could not comply with the requirement specified above in section A. Only CMS, or the FI acting on behalf of CMS, can determine if a situation encountered by an IRF is extraordinary and qualifies as a situation for waiver of the penalty.

(2) When Medicare Part A fee-for-service is not the primary payer.

150 - Long Term Care Hospitals (LTCHs) PPS
(Rev. 1, 10-01-03)
PM A-02-093

150.1 - Background
(Rev. 1, 10-01-03)

LTCHs are certified under Medicare as short-term acutecare hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under §1886(d)(1)(B)(iv) of the Act and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days. This PPS replaced the previous reasonable cost-based payment system for LTCHs.

150.2 - Statutory Requirements
(Rev. 1, 10-01-03)

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

The CMS satisfied the statutory implementation requirement by establishing October 1, 2002 as the effective date of the LTCH PPS with systems changes to follow. Payments for LTCH services furnished for cost reporting periods beginning on or after October 1, 2002 are based on the policies set forth in the August 30, 2002 final rule (67 FR 55954).

150.3 - Affected Medicare Providers
(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

LTCHs are certified under Medicare as short-term acute care hospitals and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days.

Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1) are not included in the LTCH PPS. (See 42 CFR §412.22(c).) Payment to foreign hospitals will be made in accordance with the provisions set forth in 42 CFR 413.74. Currently, two of the four Maryland LTCHs included on CMS' OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center and Deaton Hospital and Medical Center (now known as University Specialty Hospital).

150.4 - Revision of the Qualification Criterion for LTCHs

(Rev. 208, 06-18-04)

Under the LTCH PPS, the greater than 25-day average length of stay (ALOS) calculation is based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days. For cost reporting periods beginning on or after October 1, 2002, LTCHs are required to meet this revised criteria in order to qualify as LTCHs for Medicare payment purposes.

The average Medicare length of stay is calculated by dividing the total number of covered and noncovered days of care provided to Medicare patients, by the Medicare discharges occurring during that period. If the days of a stay involve days of care furnished during two or more separate cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future cost reporting period, the total number of days of the stay are considered to have occurred during the cost reporting period during which the patient was discharged. For cost reporting periods beginning on or after July 1, 2004, if a hospital fails to meet the ALOS requirement under this provision, the FI will determine the ALOS for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2005 by dividing the applicable total days for Medicare inpatients during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period.

If the FI determines that the LTCH does not qualify, FIs are to follow the procedures already established in the Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01). The new manual can be found at http://cms.hhs.gov/manuals/cmsindex.asp.

The CMS requires on-going monitoring of LTCH compliance with the above requirements as well as notification by FIs regarding this compliance.

150.5 - Payment Provisions Under LTCH PPS

(Rev. 1, 10-01-03)

Section 123 of Public Law 106-113(BBRA), as amended by §307 of Public Law 106-554(BIPA), authorizes the establishment of Federal payment rates under PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, to ensure that payment most accurately reflects cost.

The CMS has established a transition to full payments under the LTCH PPS: a 5-year phase-in during which a decreasing percentage of payments will based upon what payments would have been under the reasonable cost-based system. LTCHs may also elect to receive payment based on 100 percent of the "Federal payment rate." New LTCHs are to be paid based fully on 100 percent of the Federal rate (i.e. hospitals for which the first cost reporting period as an LTCH began on or after October 1, 2002). (See §150.10.1.)

150.5.1 - Budget Neutrality
(Rev. 1, 10-01-03)

The BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.

150.5.2 - Budget Neutrality Offset
(Rev. 1, 10-01-03)

A reduction factor to all Medicare payments during the transition to account for the monetary effect of the 5-year transition from the present cost-based payment system and the LTCH PPS, and the policy to permit LTCHs to elect payment solely under the PPS rather than based on the blend during the transition. (See §150.10.1.)

If a LTCH is paid under the transition blend methodology, the budget neutrality offset will be applied to both the TEFRA Rate Percentage and the Federal Rate percentage.

The budget neutrality offset equals 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made had the LTCH PPS not been implemented to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on the 100 percent of the Federal rate.

The per discharge Federal rates under the PPS are based on average LTCH costs in a base year updated for inflation to the first effective period of the system.

The LTCH PPS is updated annually as is done with the inpatient, IRF, and SNF/Swing bed PPS systems.

150.6 - Beneficiary Liability

(Rev. 1, 10-01-03)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system, i.e., if Medicare payments are below the cost of care for a patient under prospective payment, the patient cannot be billed for the difference.

As under the former TEFRA cost-based payment system, beneficiaries (or their Medigap insurers or other private insurers, such as an employer-sponsored plan, as applicable) are responsible for all noncovered days, where Medicare has not made a full LTC-DRG payment.

For more detailed information regarding lifetime reserve days, refer to the Medicare Benefit Policy Manual, chapter 5.

150.7 - Patient Classification System
(Rev. 1, 10-01-03)

The BBRA required the use of diagnostic-related groups (DRGs) for patient classification purposes in the PPS for LTCHs. In general, a case is grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings are called LTC-DRGs, which are based on the existing CMS DRGs used under the acute care hospital inpatient PPS. Patient discharges are grouped using ICD-9- CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.

The same GROUPER software developed by 3M for the acute care hospital inpatient PPS, is used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients).

150.8 - Relative Weights
(Rev. 1, 10-01-03)

Payment weights assigning a specific value representing the relative resource use of each LTC DRG are determined by the hospital-specific relative value method. This methodology normalizes charges within each hospital and then compares them across hospitals. Relative weights are updated annually October 1 using the most recent available claims data. Relative weights and the geometric average length of stay are in the Pricer program.

150.9 - Payment Rate
(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Payments to LTCHs under the LTCH PPS are based on a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary

services), but not certain pass through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors). This single standard Federal rate is updated annually by the excluded hospital with capital market basket index. The formula for an unadjusted LTCH PPS prospective payment is as follows:

- Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate Case-Level Adjustments

Effective July 1, 2003, the annual update to the standard Federal rate is based on the "LTCH PPS rate year" of July 1 through June 30, rather than the Federal fiscal year (October 1 through September 30). July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

150.9.1 - Case-Level Adjustments

(Rev. 1, 10-01-03)

Payments are based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments are applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

150.9.1.1 - Short-Stay Outliers

(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

- Generally, a short-stay outlier (SSO) is a case that has a covered length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. Effective for LTCH PPS discharges occurring on or before June 30, 2006, the adjusted payment for an SSO case is the least of:

    - 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio (CCR) and covered charges from the bill);

    - 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or

    - The full LTC-DRG payment.

To compute 120% of cost:

- Charges x CCR = Cost ($13,870.33) x (0.8114) = $11,254.39

- 120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

  Full LTC-DRG payment:

  $34,956.15 (FY 2003 standard Federal rate)

  x 0.72885 (labor %)

  $25,477.79 (labor share)

  x 1.0301 (1/5th wage index value for FY 2003)

  $26,244.67 (wage adjusted labor share)

  + 9,478.36 (non-labor share=$34,956 x 0.27115)

  $35,723.03 (adjusted standard Federal rate)

  x 1.4103 (LTC-DRG 113 relative weight)

  $50,380.19 (full LTC-DRG payment

  Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

  If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this example, the case is paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

For RY 2007, the SSO policy was revised as follows:

- Effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case is equal the least of:
  - 100 percent of estimated cost of the case,

- 120 percent of the LTC-DRG per diem amount,
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

Under the blend alternative, the percentage of the 120 percent LTC-DRG per diem amount is based on the ratio of the (covered) length of stay of the case to the lesser of the SSO threshold for the LTC-DRG (i.e., 5/6ths of the geometric ALOS of the LTC-DRG) or 25 days. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the adjusted SSO payment is no longer be limited by this fourth option. This is because for SSO cases with a LOS of 25 days or more, the amount determined under the blend alternative is equal to 100 percent of the 120 percent of the LTC- DRG specific per diem amount and 0 percent of the IPPS comparable per diem amount. In addition, the LOS in the numerator cannot exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent). The remaining percent of the blend alternative (that is, 100 percent minus the percentage applied to the 120 percent of the LTC-DRG per diem amount) is applied to the IPPS comparable per diem amount (capped at the full IPPS comparable amount).

The following examples illustrate how the blend alternative is calculated when the LTCH patient is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC DRG payment is $38,597.41, the LTCH PPS geometric ALOS is 33.6 days, the LTCH PPS SSO threshold (i.e., 5/6ths of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is $8,019.82, and the IPPS geometric ALOS is 4.5 days.

SSO Example #1 – LOS equals 11 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x11 days x 1.2 33.6 days	$15,163.27
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days	11 days ÷ 25 days	0.44
1c	Determine the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a)	0.44 x $15,163.28	$6,671.84
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$19,604.00
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($19,604.00)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 0.44	0.56
2d	Determine the IPPS comparable per diem portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable amount determined in step (2-b)	0.56 x $8,019.82	$4,491.10
3	Compute the blend alternative	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$6,671.84 + $4,491.10	$11,162.94

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in

the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

SSO Example #2 – LOS equals 27 Days:

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2	$38,597.41 x 27 days 33.6 days x 1.2	$37,218.93
1b*	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days; however, since the LOS in the numerator exceeds the number of days in the denominator, the percentage equals 100 percent	27 days ÷ 25 days is > 1; therefore percent is 1.00	1.00
1c	Determine the 120 percent of the LTC-DRG per diem portion of the blend alternative	Multiply the percentage determined in step (1-b) by the 120 percent of the LTC-DRG per diem amount in step (1-a)	1.0 x $37,218.93	$37,218.93
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS	$8,019.82 x 11 days 4.5 days	$48,118.92
2b	Determine the IPPS comparable per diem amount to be used in the blend alternative	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($48,118.92)	$8,019.82
2c	Calculate the percentage of the IPPS comparable per diem amount	Subtract the percentage determined in step (1-b) from 1 (i.e., 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days)	1 – 1.00	0.00
2d	Determine the IPPS comparable per diem amount portion of the blend alternative	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b)	0.00 x $8,019.82	$0.00

3	Compute the blend alternative	Add the 120 percent of the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d)	$37,218.93 + $0.00	$37,218.93 **

* In this example, 25 days was used in the denominator since the 5/6th ALOS of LTC DRG XYZ (28.0 days) is greater than 25 days. If the 5/6th ALOS of LTC-DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (i.e., the percentage may not exceed 100 percent).

** Note that, since in this example the LOS of the SSO case exceeds 25 days, the blend percentage applicable to the 120 percent of the LTC-DRG specific per diem amount is 100 percent and the percentage applicable to the IPPS comparable per diem amount is 0 percent, therefore the amount computed under the blend option is equal to 120 percent of the LTC-DRG specific per diem amount.

Under the blend alternative of the SSO payment formula, an amount comparable to what would otherwise be paid under the IPPS (i.e., full IPPS comparable amount) includes payment for the costs of inpatient operating services based on the standardized amount determined under §412.64(c), adjusted by the applicable DRG weighting factors determined under §412.60 as specified at §412.64(g). This amount is further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at §412.525(c) and using the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently, the same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, an amount comparable to what would be paid under the IPPS for the case includes a disproportionate share (DSH) adjustment (see §412.106), if applicable, and includes an indirect medical education (IME) adjustment (see §412.105), if applicable. For the comparable IPPS DSH adjustment, provider specific file elements 24 (Bed Size), 27 (Supplemental Security Income Ratio (SSI)), and 28 (Medicaid Ratio) are required, as discussed below. In determining a LTCH's SSI ratio and Medicaid ratio used in the calculation of the comparable IPPS DSH adjustment, refer to sections 20.3.1.1 and 20.3.1.2 of this manual.

For the comparable IPPS IME adjustment, provider specific file elements 23 (Intern/Beds Ratio) and 49 (Capital Indirect Medical Education Ratio) are required, as discussed below. Furthermore, the IPPS comparable IME adjustment for a LTCH is determined by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap as set forth at §413.79(c)(2) (which will already be established for a LTCH which had residency programs). In determining the

IPPS comparable IME adjustment for a LTCH, if applicable, the use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. The full IPPS comparable amount used under the blend alternative in the SSO payment adjustment, also includes payment for inpatient capital-related costs, based on the capital Federal rate at §412.308(c), which is adjusted by the applicable IPPS DRG weighting factors. This amount is further adjusted by the applicable geographic adjustment factors set forth at §412.316, including wage index (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as published in the annual IPPS final rule), and large urban location, if applicable. A LTCH PPS payment amount comparable to what would be paid under the IPPS does not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§412.80(a)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at §412.525(a)(1) (i.e., if the estimated costs of the case exceeds the adjusted LTCH PPS SSO payment plus the fixed-loss amount) will receive an additional payment under the LTCH PPS HCO high cost outlier at §412.525(a) (67 FR 56026; August 30, 2002). Under the revised SSO payment formula, we will continue to use the fixed-loss amount calculated under §412.525(a), and not a fixed-loss amount based on §412.80(a), to determine whether a SSO case receives an additional payment as a high cost outlier case.

For RY 2008, the SSO policy was revised as follows:

Effective for LTCH PPS discharges occurring on or after July 1, 2007, and on or before December 28, 2007*, the payment adjustment formula for SSO cases was revised for those cases where the patient's LTCH covered LOS is less than, or equal to an "IPPS-comparable" threshold. For cases falling within this "IPPS-comparable" threshold, Medicare payment under the SSO policy is subject to an additional adjustment.

The IPPS-comparable threshold is defined as the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029)).

If the covered LOS at the LTCH is less than or equal to the IPPS-comparable threshold for the LTC-DRG, Medicare payment is based on the IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option replaces the "blend" amount in the adjusted LTCH PPS SSO payment formula.

Effective for discharges occurring on or after July 1, 2007 and on or before December 28, 2007*, therefore, the adjusted Medicare payment for an SSO case where the covered LOS at the LTCH is within the IPPS-comparable threshold, is equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,

- the full LTC-DRG payment, or

- the "IPPS comparable" per diem amount , capped at the full IPPS comparable amount

The IPPS comparable amount is determined by the same methodology as the IPPS comparable portion of the blend alternative, specified above in the above examples at 2a.

For SSO cases where the covered length of stay exceeds the "IPPS threshold," payment is made under the SSO payment formula that became effective beginning in RY 2007, as specified above.

***NOTE:** On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the Act. Specifically, section 114(c)(3) of the MMSEA specifies that the revision to the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Consequently, the fourth option in the SSO payment adjustment formula at §412.529(c)(3)(i) will not apply during this 3-year period, and therefore, there will be no comparison of the covered LOS of the SSO case to the "IPPS threshold" in determining the payment adjustment for SSO cases. Therefore, for SSO discharges occurring on or after December 29, 2007, and before December 29, 2010, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case,

- 120 percent of the LTC-DRG per diem amount,

- the full LTC-DRG payment, or

- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the "IPPS threshold") are paid under the SSO payment formula that became effective beginning in RY 2007, as described above.

Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)

A "subsection (II)" hospital:

- Was excluded as a LTCH in 1986

- Has an average inpatient LOS of greater than 20 days, and

- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a "subsection (II)" hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., **discharges** occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or120 percent of the per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for **discharges** occurring on or after **July 1, 2003 through the first year of transition 195%**;

- Effective for **discharges** during the second year of the transition, **193%**;

- Effective for **discharges** during the third year of the transition, **165%**;

- Effective for **discharges** during the fourth year of the transition, **136%**; and

- Effective for **discharges** for the last year and thereafter, the percentage returns to **120%**.

150.9.1.2 - Interrupted Stays

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at an LTCH during which the beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one limited exception: for RY 2005 and RY 2006, if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Effective for dates of service on or after July 1, 2006 (RY 2007**)**, this limited exception for surgical DRGs is no longer applicable. No further separate payment to an acute care hospital will be made. Any tests or procedures, that were administered to the patient during that period of time of interruption will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the3-day or less interruption (e.g., the patient is home and doesn't receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for "under arrangements," all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

- The original interrupted stay policy is now defined as "a greater than 3-day interruption of stay" and is a stay in which a LTCH patient that is admitted upon discharge to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or swing bed and returns to the same LTCH within a specified period of time. The day count begins on the day of discharge from the LTCH, which is also the admission day to the other provider, and ends on the day of readmission to the LTCH.

    - For an acute care hospital: between 4 and 9 consecutive days;
    - For an IRF: between 4 and 27 consecutive days;
    - For a SNF: between 4 and 45 consecutive days; and
    - For a Swing Bed: between 4 and 45 consecutive days or less.

Note that although the greater than 3-day interruption of stay policy only governs when a patient is away from the LTCH for between 4 days and the applicable provider threshold, the day count for determining whether the threshold is met begins when the patient is discharged. So if a patient is discharged on 9/2/04, the 3-day or less interrupted stay policy will govern payment if the patient is readmitted to the LTCH on 9/2, 9/3, or 9/4. If the patient is readmitted to the LTCH on 9/5, payment will be paid to, for example, the acute care hospital which provided treatment, but the day count for determining whether or not the stay is one interrupted stay or a whether the return to the LTCH is a separate admission starts on 9/2. For example, if the LTCH discharges a patient to an acute care hospital on 9/2/04, if they are readmitted to the LTCH by 9/10/04, this is an interrupted stay. If they are readmitted on 9/11/04, it counts as a separate admission. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made. (The bill generated by the original stay in the LTCH should be cancelled by the provider or they may do a debit/credit adjustment.)

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

If the length of stay at the "receiving" site of care exceeds the above- specified period of time, the return to the LTCH is a new admission. This means that the original discharge to that site is treated as a discharge for payment purposes.

For the percentage of payments that are to be made under the TEFRA system during the 5-year transition, the FI treats each segment of the interrupted stay as a separate discharge. (FIs are to follow the same procedure as provided under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

150.9.1.3 - Payments for Special Cases

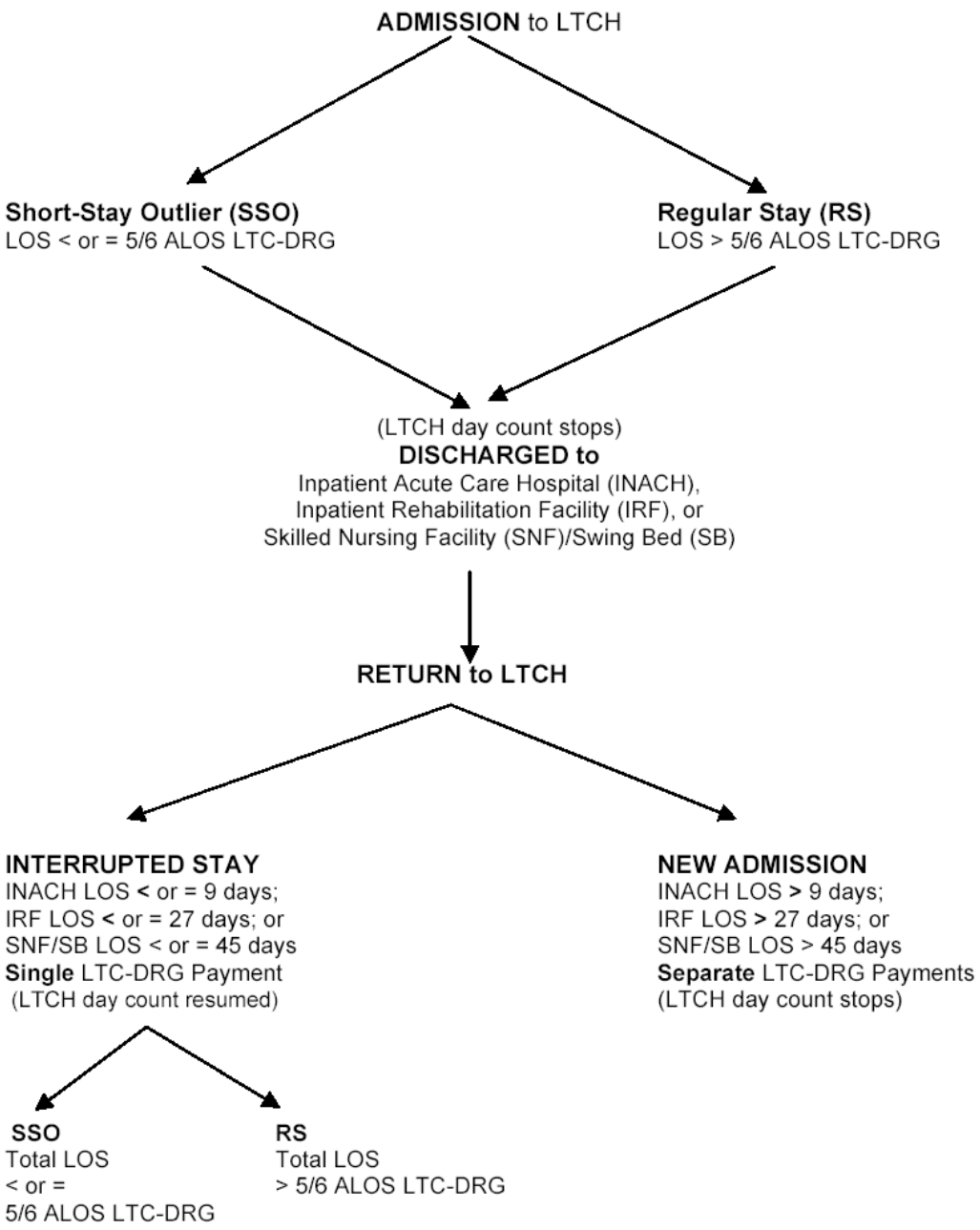
(Rev. 208, 06-18-04)

- Payments for short-stay outliers are determined in the Pricer logic.

- Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. The following flow chart describes the order that is used to assess whether or not the adjustments apply. For example, a case may be a short-stay outlier and also be governed by either the 3-day or less or greater than 3-day interruption of stay policy and therefore only generate 1 LTC-DRG payment to the LTCH.

SHORT-STAY OUTLIERS AND INTERRUPTED STAYS



150.9.1.4 - Payment Policy for Co-Located Providers
(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Hospitals within hospitals (HwH), satellite facilities, and onsite SNFs:

The LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, **all** such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)

- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

The LTCHs were required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the FIs within 60days of such a change. The implementation of the onsite policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

Beginning FY 2005, an additional payment adjustment was established for LTCH HwHs and satellites of HwHs relating to the percentage of patients discharged during a specific cost reporting period that were admitted from their host hospital. Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes discharges from "grandfathered" LTCH HwHs and LTCH satellites that were admitted from their host hospitals; LTCH and LTCH satellite discharges from referring hospitals that are not co-located with the discharging facility; and discharges from "free-standing" LTCHs that were admitted from any referring hospital.

Basic Payment Formula under the 25 Percent Threshold Payment Adjustment for Medicare Discharges from Referring Hospitals

NOTE: On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted with mandated several modifications to this policy for a 3-year period beginning on the date of enactment of the Act. For clarity, each modification to the policy is specified in a bullet point immediately below the explanation of the particular aspect of the policy as it was effective on July 1, 2007.

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**

    - This policy was finalized for FY 2005

- If a LTCH HwH or satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. For LTCHs and LTCH satellites subject to the transition period described below, there is a 3-year transition to the f ull 25 percent threshold payment adjustment.

  As amended by the MMSEA of 2007:

    - The percentage threshold for "applicable" LTCHs and LTCH satellites (i.e., subject to the transition described below) is raised from 25 percent to 50 percent for LTCH cost reporting periods beginning on or after December 29, 2007 and before December 29, 2010.

    - For LTCHs with "special circumstances," specified below, the 50 percent threshold is raised to 75 percent for the same 3-year period.

    - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to Grandfathered LTCH HwHs and LTCH Satellites from their Host Hospitals**

    - This policy is effective for cost reporting periods beginning on or after July 1, 2007.

    - Subject to the 3-year transition described below, if a grandfathered LTCH HwH or a grandfathered satellite of a LTCH has admitted from its host hospital in excess of 25 percent or the applicable percentage) of its

discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.

As amended by the MMSEA of 2007:

- For cost reporting periods beginning on or after December 29, 2007, and before December 29, 2010, grandfathered LTCH HwHs are exempted from the 25 percent threshold for admissions from co-located hospitals or referring hospitals with which they are not co-located.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to all LTCHs and LTCH Satellites from Referring Hospitals other than those with which they are Co-located:**

  - This policy is effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition specified below, if a LTCH or LTCH satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As amended by the MMSEA of 2007:

- "Freestanding" LTCHs, i.e., LTCHs not co-located with another hospital as a HwH or as a satellite are exempted from the 25 percent threshold for admissions from any referring hospital.

An amount that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located and the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, an amount equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment and where applicable, an IME adjustment.

Additionally, to arrive at the payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted by the applicable geographic adjustment factors set forth, including local cost variation (based on the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule), large urban location, and COLA, if applicable.

For discharges governed by this payment, an amount that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment if applicable, and an equivalent IME adjustment), if applicable.

An amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since, under the IPPS, there are separate Medicare rates for operating and capital costs to acute care hospitals, while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospital's services provided to LTCH Medicare patients.

Note that there is a difference between the policy that we have codified for adjusted payments to LTCH HwHs and satellites of LTCHs, which is based on an amount "equivalent" under the existing payment, and the additional component to the SSO payment adjustment that is based on an amount "comparable" to what would otherwise be paid under the IPPS adjustment. The distinction is that if a SSO case also qualifies as a high cost outlier (HCO) case after the SSO payment amount is determined, the SSO payment formula uses the LTCH PPS fixed loss amount. In contrast, under the payment adjustment for LTCH HwHs and LTCH satellites if the amount payable by Medicare for a specific case is equivalent to what would be otherwise payable under the IPPS and the case also qualified as a HCO, the outlier payment for this case would be based on the IPPS HCO policy because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment the lesser amount resulted in an "otherwise payable amount under the LTCH PPS," and the stay qualified as a HCO, Medicare would generate a HCO payment governed by the LTCH

PPS fixed loss amount calculated under the LTCH PPS and if the estimated cost of the case exceeds the adjusted LTC-DRG plus a fixed loss amount under §412.525(a), the LTCH would receive an additional payment based on the LTCH PPS HCO policy.

Specific Circumstances (applicable to all of the above scenarios)

NOTE: MMSEA changes described above applicable for cost reporting periods beginning on or after December 29, 2007, and before December 29, 2010.

- For LTCHs and LTCH satellites located in rural areas, instead of the 25 percent threshold, we provide for a 50 percent threshold for patients from any individual referral hospital. In addition, in determining the percentage of patients admitted from that referring hospital, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital.

- For urban single or MSA dominant referring hospitals, we would allow the LTCH or LTCH satellite to admit from the host up to the referring hospital's percentage of total Medicare discharges in the MSA. A floor of 25 percent and a ceiling of 51 percent applied to this variation.

Transition Periods

For Medicare discharges from referring hospitals:

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**

  - This policy was finalized for FY 2005.

This payment adjustment will be phased-in over 4 years for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and

- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the hospital's cost reporting period during FY 2004 that were admitted from the host hospital.

Year 1 -- (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"

- Payments will be made under the LTCH PPS but the percentage of LTCH HwH discharges originating from the host may not exceed the percentage for such patients established for cost reporting periods during FY 2004.

Year 2 -- (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 -- (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 4 -- (cost reporting periods beginning on or after October 1, 2007 through September 30, 2008)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent or the applicable percentage described for "specific circumstances above."

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Transition Period for all LTCHs affected by the Above Described Regulations for cost reporting periods beginning on or after July 1, 2008.

NOTE: MMSEA changes described above applicable for cost reporting periods beginning on or after December 29, 2007, and before December 29, 2010, for "grandfathered" LTCH HwHs and "freestanding" LTCHs.

The full payment threshold adjustment will be phased in over 3-years as follows:

Year 1 - (for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008)

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 2 - (for cost reporting periods on or after July 1, 2008 through June 30, 2009),

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 - (for cost reporting periods on or after July 1, 2009)

- All LTCHs and LTCH satellites subject to the payment threshold policy effective for RY 2008, will be subject to the 25 percent (or applicable percentage) threshold.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Implementation:

- The payment threshold policy for discharges from co-located LTCH HwHs and LTCH satellites admitted from their hosts (including grandfathered LTCH HwHs and satellites) is determined based on a location-specific basis.

- The payment threshold policy for discharges from LTCHs and LTCH satellites admitted from referring hospitals with which they are not co-located is determined based upon provider numbers for both the LTCH and the referring hospital.

For LTCHs and LTCH satellites subject to both the FY 2005 and the RY 2008 threshold payment adjustment policies

- If a co-located LTCH or a co-located referring hospital (host) shares a provider number with a hospital or satellite at another location, threshold determinations will continue to be location-specific for the co-located LTCH and host. The threshold percentage determinations will be applied to all other location or campus of either a LTCH or referring hospital in the aggregate. For example, when the policy finalized for RY 2008 is fully phased in, a co-located LTCH (LTCH A) and host (referring hospital A) will have a 25 percent threshold under the policy finalized for FY 2005. If referring hospital A shares a provider number with a remote location (RH A'), then another 25 percent threshold will be applied to patients discharged from LTCH A that were admitted RH A'.

- We note that for cost reporting periods beginning on or after October 1, 2007, non-grandfathered co-located LTCHs, are fully phased-in to the full 25 percent (or applicable percentage threshold) for discharges admitted from their co-located hosts (under the initial 25 percent payment threshold established for FY 2005)s.

- However, for discharges admitted from non-co-located referring hospitals, these LTCH HwHs and satellites are governed by the policy finalized for RY 2008. Therefore, for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008, the 75 percent threshold will apply, and the 50 percent threshold will apply for cost reporting periods beginning on or after July 1, 2008 through June 30, 2009 as described above in this response.)

- Furthermore, under our finalized policy for RY 2008, grandfathered LTCH HwHs and satellites will be subject to the 3-year transition that we are finalizing under this new policy for <u>all</u> their discharges, both admitted from their co-located host and from other non-co-located referring hospitals.

When both policies apply:

If a patient discharged from a LTCH HwH or satellite was originally admitted from the host hospital and immediately prior to that admission to the host, the patient was being treated at the same LTCH HwH or LTCH satellite, both of the policies described in this section, the 5 percent on-site policy as well as the 25 percent policy are applicable. In such a case, the following procedures should be followed keeping in mind that the 5 percent rule affects number of discharges and the 25 percent rule affects payment.

- The on-site 5 percent computation is first in order to determine the real number of discharges.

- Focusing on the relationship between an acute host and a LTCH HwH/satellite, if the number of revolving door discharges between these two facilities exceeds 5 percent during a CR period, this policy will collapse the number of discharges within that CR period, halving the # of revolving door LTCH stays where the intervening stay exceeded the threshold and eliminating from consideration those host stays that were bracketed by two LTCH stays. All such stays for the entire cost reporting period will be paid as one LTCH PPS stay.

- The next issue is to determine which of these stays will be paid an unadjusted LTCH PPS rate and which will be paid an amount equivalent to what would otherwise be paid under the IPPS. Cases prior to tripping the 25 percent threshold will be paid the otherwise unadjusted LTCH PPS rate and those after the threshold that had not achieved outlier status at the host it will be paid based on the adjustment.

- Because of the 5 percent policy that collapsed the discharges from the LTCH, for purposes of the 25 percent policy, we are focusing on fewer discharges in total from the LTCH and we need to determine what percent of these discharges originated in the host so that we can apply the payment adjustment.

BUT, in the event that the 5 percent is not tripped during that cost reporting period, each acute-->LTCH-->acute--> LTCH cycle, which will count as two LTCH discharges originating in the host for purposes of the 25 percent policy, since both the first and second LTCH admission were from the host.

150.9.1.5 - High Cost Outlier Cases

(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Additional payments are made for those cases that are considered high cost outliers. A case falls into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). (Short-stay outliers, described above, are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short-stay outlier cases.)

The fixed loss amount is determined annually on July 1 such that projected outlier payments are equal to 8 percent of total LTCH PPS payments. July 1, 2008, is the final rate year; LTCH PPS is moving back to a Federal Fiscal Year effective October 1, 2009.

If the estimated cost of the case is greater than the outlier threshold an additional payment is added to the LTC-DRG payment amount.

The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

For discharges occurring on or after August 8, 2003, (high cost outlier payments may be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

150.10 - Facility-Level Adjustments

(Rev. 1547, Issued: 07-03-08; Effective: 07-01-08; Implementation: 07-07-08)

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "appropriate adjustments to the long-term hospital payment system."

Variables examined include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

- The system includes an area wage adjustment that is being phased in over 5 years.
- The wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.

- A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under §§1886(d)(8) - (10) of the Act. Effective July 1, 2005, an LTCH wage index is based on the Core-Based Statistical Area (CBSA).

- The phase-in of the wage index adjustment is as follows:

Cost Reporting Periods Beginning During	Applicable Wage Index Value
FY 2003	1/5th of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2004	2/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2005	3/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage

Cost Reporting Periods Beginning During	Applicable Wage Index Value
	index
FY 2006	4/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2007	Full value (5/5^{ths}) of the value of the applicable pre-reclassification, no floor hospital inpatient wage index

Based on analyses of patient charge data from FYs 2000 and 2001 MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there is no empirical evidence to support other adjustments. Therefore, for the present, there are no adjustments for DSH, IME, or geographic reclassification.

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

- The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the acute care hospital inpatient PPS).

- Annual updates for the LTCH PPS appear in **Federal Register** publications: for payment rates and associated adjustments, see the LTCH PPS final rule with an effective date of July 1. Annual updates of the LTC-DRGs are published in the IPPS final rule with an effective date of October 1.

- The COLA factors effective July 1, 2004 are the same as under the acute care hospital inpatient PPS and are as follows:

Area	COLA
Alaska:	
All Areas	1.25
Hawaii:	
Honolulu	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

Cost-of-Living Adjustment Factors: Alaska and Hawaii Hospitals Area Cost of Living Adjustment Factor effective for discharges on and after October 1, 2008.

Alaska:
City of Anchorage and 80-kilometer (50-mile) radius by road 1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road 1.24
City of Juneau and 80-kilometer (50-mile) radius by road 1.24
Rest of Alaska 1.25

Hawaii:
City and County of Honolulu 1.25
County of Hawaii 1.17
County of Kauai 1.25
County of Maui and County of Kalawao 1.25

150.10.1 - Phase-in Implementation
(Rev. 1, 10-01-03)

The PPS for LTCHs is to be phased-in over a five- year period from cost-based reimbursement to Federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	LTCH PPS Federal Rate Percentage	TEFRA Rate Percentage
October 1, 2002, through September 30, 2003	20	80
October 1, 2003, through September 30, 2004	40	60
October 1, 2004, through September 30, 2005	60	40
October 1, 2005, through September 30, 2006	80	20
October 1, 2006	100	0

The LTCHs can exercise a one-time irrevocable option to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment. To exercise this option, for cost reporting periods beginning on or after October 1, 2002, and before December 1, 2002, the LTCH was to notify its FI of this election in writing, and it was to be received by the FI no later than November 1, 2002. To exercise this option, for cost reporting periods beginning on or after December 1, 2002, the LTCH must notify its FI in writing 30 days prior to the start of the LTCH's next cost reporting period.

Payments to new LTCHs, i.e., a hospital that has its first cost reporting period as a LTCH beginning on or after October 1, 2002, are made based on 100 percent of the standard Federal rate.

NOTE: under the BIPA, during cost reporting periods beginning during FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the TEFRA portion of transitions payments.

150.11 - Requirements for Provider Education and Training
(Rev. 1, 10-01-03)

Training resources are available for FI staff to use in training providers about the Long Term Care Hospital Prospective Payment System (LTCH PPS). The train-the-trainer process for LTCH PPS does not include in- person instruction for FIs. Instead, CMS provides various educational resources for FIs to learn about LTCH PPS.

The CMS provides the following LTCH PPS education resources for FIs:

- A training guide is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp;
- A training video was mailed to FIs;
- A PowerPoint presentation for training providers is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp; and
- An e-mail mailbox was established to address questions. Send questions to: LTCHPPS@cms.hhs.gov.

150.12 - Claims Processing and Billing
(Rev. 1, 10-01-03)

150.12.1 - Processing Bills Between October 1, 2002, and the Implementation Date
(Rev. 1, 10-01-03)

Claims submitted prior to implementation were processed under the current methodology. On or after January 1, 2003, submit mass adjust claims under the PPS payment methodology by April 30, 2003. The shared systems is creating a mass adjustment program.

Beginning October 16, 2003, all LTCHs are required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding. All ICD-9-CM coding must be used for LTCH providers with cost reporting period beginning on or after October 1, 2002.

150.13 - Billing Requirements Under LTCH PPS
(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to incorporate the following so that FIs accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X.

This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper software will determine DRG assignment.

Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill (note that the day in which benefits exhaust is considered a "discharge" for payment purposes).

Effective December 3, 2007, once a patient's Medicare benefit's exhaust, the LTCH is allowed to submit no-pay bills until physical discharge or death.

150.14 - Stays Prior to and Discharge After PPS Implementation Date
(Rev. 1, 10-01-03)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under LTCH PPS, payment to the facility is based on LTCH PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider needs to submit cancels for all bills and then rebill once the cancels are accepted.

150.14.1 - Crossover Patients in New LTCHs
(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to a LTCH, payment issues arise for "cross-over" patients who were admitted prior to the change in classification who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as hospitals and generally be paid under the IPPS, for 6 months prior to designation as a LTCH, in 42 CFR 412.23(e), there are "cross-over patients," at the creation of every LTCH, who were admitted to the facility when it was an acute care hospital. The policy was to discharge the patient under the acute provider number and readmit the patient under the new LTCH provider number (see section 100.4.1 of this chapter). Medicare paid twice for what was really one episode of care since separate payment would be made to both the acute hospital and the LTCH. Effective October 1, 2004, Medicare will issue one discharge-

based payment to the LTCH that discharges the patient, under the applicable payment system.

In the regulations at 42 CFR 412.521(e) we provide a payment methodology for such cases in which Medicare will consider all the days of the patient stay in the facility (both prior to and following the date of LTCH designation) to be a single episode of LTCH care. Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Furthermore, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3).

Bills paid to the facility for crossover patients when the facility was paid under IPPS must be canceled, so that the entire stay can be billed under the LTCH provider number and paid for under LTCH PPS.

150.15 - System Edits

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The Shared systems and/or Common Working File (CWF) must ensure:

- That revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- That the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;

- That Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the LTCH in a specified amount of time). See section 150.9.1.2.

If the interruption is greater than the specified number of days applicable to the specific provider, the bill is considered a discharge and two bills would exist if the beneficiary returns to the same LTCH, otherwise it is considered an interruption with one DRG payment associated. CWF will edit for both of these situations.

Payments under the onsite discharge and readmittance policy are to be reconciled at cost report settlement, at which time it is possible to determine the total number of such cases that have occurred during that cost reporting period.

The accommodation revenue code 018X, (leave of absence) continues to be used in the current manner in terms of Occurrence Span code 74 and date range.

150.16 - Billing Ancillary Services Under LTCH PPS

(Rev. 1, 10-01-03)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes continue to be shown in FL 42, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- LTCHs are required to report the number of units in FL 46 based on the procedure or service.

- LTCHs are required to report the actual charge for each line item, in Total Charges, FL 47.

- In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS.

150.17 - Benefits Exhausted

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The day benefits exhaust is considered a "discharge" for payment purposes under LTCH PPS.

If a beneficiary's Part A benefits exhaust during the stay, providers code an Occurrence Code A3-C3. If benefits are exhausted prior to the stay, hospitals submit a no-pay claim that is to be coded by the FI with no pay code B.

LTCH PPS uses Occurrence Code 47 to indicate the first full day of cost outlier status and also uses Occurrence Span Code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

150.17.1 – Assumptions for Use in Examples Below

(Rev. 1, 10-01-03)

1. Cost outlier threshold amount is $50,000

2. Threshold amount is reached on the 25th day

3. The DRG ALOS equals 12 days, therefore, the Short Stay Threshold equals 10 days

4. Billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter

5. Beneficiary elects to use any available LTR days

150.17.1.1 - Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)
(Rev. 1, 10-01-03)

1a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 9 coinsurance and 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 9

LTR days used: 21

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

1b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 coinsurance and 0 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 9

LTR days used: 0

Cost report days: 9

OC A3: 1/09/03

Reimbursement: Short stay outlier

1c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 9 coinsurance and 10 LTR

Covered days: 19

Noncovered days: 11

Coinsurance days used: 9

LTR days used: 10

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/20/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.2 - Example 2: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)
(Rev. 1, 10-01-03)

2a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 15 coinsurance and 60 LTR

Covered days: 20

Noncovered days: 10

Coinsurance days used: 15

LTR days used: 5

Cost report days: 30

OC 47: 1/26/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

2b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 15 coinsurance and 3 LTR

Covered days: 18

Noncovered days: 12

Coinsurance days used: 15

LTR days used: 3

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

2c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 15

Coinsurance days used: 15

LTR days used:0

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.3 - Example 3: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (20 day stay)

(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/21/03

Medically necessary days: 20

Covered charges: $45,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 5

Coinsurance days used: 15

LTR days used: 0

Cost report days: 20

OSC 70: 1/16/03 - 1/20/03

Reimbursement: Full DRG payment

150.17.1.4 - Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)

(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 0

LTR days used: 9

Cost report days: 9

OC A3: 1/09/03
Reimbursement: Short stay outlier payment

150.17.1.5 - Example 5: Only LTR Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

5a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 12 LTR

Covered days: 12

Noncovered days: 18

Coinsurance days used: 0

LTR days used: 12

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/13/03 - 1/25/03

Reimbursement: Full DRG payment

5b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 0

LTR days used: 30

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

5c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 28 LTR

Covered days: 28

Noncovered days: 2

Coinsurance days used: 0

LTR days used: 28

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

150.18 - Provider Interim Payment (PIP)
(Rev. 1, 10-01-03)

PIP applies to LTCH PPS. Outlier payments in regards to PIP are handled the way they currently are under other inpatient PPS systems.

150.19 - Interim Billing
(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Interim bills are allowed every 60 days. Refer to Chapter 1, section 50.2 for specifics on interim billing under PPS.

Effective December 3, 2007, LTCHs are allowed to submit no-pay bills (TOB 110) once benefit's exhaust, every 60 days. They do not have to continually adjust bills until physical discharge or death once benefit's exhaust. The last bill shall contain a discharge patient status code.

150.20 – FI Benefit Payment Report (IBPR)
(Rev. 1, 10-01-03)

The IBPR report changes to reflect the payments for LTCHs going to PPS free-standing hospitals.

150.21 - Remittance Advices (RAs)
(Rev. 1, 10-01-03)

Reason and remark codes already in existence for inpatient hospital PPS apply under this PPS.

150.22 - Medicare Summary Notices (MSNs)
(Rev. 1, 10-01-03)

Use existing notices for inpatient hospital PPS for LTCH PPS.

150.23 - LTCH Pricer Software
(Rev. 1, 10-01-03)

The CMS developed a LTCH Pricer program that calculates the Medicare payment rate.

Pricer software is electronically supplied to the Shared systems. Pricer pays a short-stay outlier if the stay is between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG.

- Pricer incorporates the five-year phase-in period for those providers that choose to be paid on the blended rate.

150.23.1 - Inputs/Outputs to Pricer
(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Inputs

- Provider Specific File Data; Fields-1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 25 (although this field refers to the operating cost/charge ratio, for LTCH, entered here will be a combined operating and capital cost/charge ratio). Effective July 1, 2005, FIs shall no longer populate fields 12, 13, or 14. Field 35 must be populated for all LTCHs. Fields 33 and 38 shall be populated if applicable. Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required. See the section "Determining the Cost-to-Charge Ratio" below for determining the cost/charge ratio.

- The facility-specific rate (Field 21) will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS were not being implemented.

- Bill Data

    - Provider #

- Patient Status
- Covered Charges
- Discharge Date (or benefit's exhaust date if present (Occurrence Code A3, B3, or C3))
- Length of Stay (LOS)
- Covered Days
- Lifetime Reserve Days (LTR)
- DRG (from Grouper)

Outputs

- PPS Return Code
- MSA/CBSA (CBSAs will be returned for discharges on or after July 1, 2005).
- Wage Index
- Average LOS
- Relative Weight
- Final Payment Amount
- DRG Adjusted Payment Amount
- Federal Payment Amount
- Outlier Payment Amount
- Payment Amount
- Facility Costs
- LOS
- Regular Days Used
- LTR Days Used

- Blend Year, 1-5
- Outlier Threshold
- DRG
- COLA
- Calculation Version Code
- National Labor Percent
- National Non-Labor Percent
- Standard Federal Rate
- Budget Neutral Rate
- New Facility-specific Rate

150.24 - Determining the Cost-to-Charge Ratio
(Rev. 1, 10-01-03)

This section describes the appropriate data sources for computing an overall Medicare hospital specific cost-to-charge ratio for the purpose of determining short-stay outlier payments at §412.529 and high cost outlier payments at §412.525(a) under the LTCH PPS.

- For discharges occurring before August 8, 2003, FIs are to use the latest available settled cost report and associated data in determining each LTCH's overall Medicare cost-to-charge ratio. Updated cost-to-charge ratios should be calculated each time a subsequent cost report settlement is made. No retroactive adjustments are to be made to outlier payments upon cost report settlement.

- For discharges occurring on or after August 8, 2003, FIs may use an alternative cost-to-charge ratio, as directed by CMS, which more accurately reflects recent substantial increases/decreases in a hospital's charges. LTCHs may also request that FIs use a different (higher or lower) cost-to-charge ratio based on substantial evidence and approval by the respective CMS Regional Office.

- For discharges occurring on or after October 1, 2003, FIs calculate a LTCH's cost-to-charge ratio from the latest settled or tentatively settled cost report, whichever is later. Updated cost-to-charge ratios are to be calculated each time a subsequent cost report is settled or tentatively settled.

- For discharges occurring on or after August 8, 2003, (high cost and short-stay) outlier payments may be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

The LTCH PPS covers operating and capital-related costs and excludes the costs of bad debts, medical education, nurse anesthetist, and blood clotting factors, which are paid for on a reasonable cost basis.

- Total Medicare charges for LTCHs will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital).

- Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only.

- For LTCHs, overall Medicare cost-to-charge ratios will be based on the latest settled cost report data unless such data are either unavailable or outside the ranges noted below.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare cost-to-charge ratio cannot be calculated (i.e., "new" LTCHs) or is not reasonable, the appropriate urban or rural statewide operating and capital average calculated annually by CMS under the Hospital Impatient PPS and published in the Federal Register **is to** be used. For FY 2004, the statewide average operating and capital cost-to-charge ratios can be found in Tables). For "new" LTCHs, use the Hospital Inpatient PPS statewide averages until the LTCH's actual cost-to-charge ratio can be computed using the first settled cost report data; then the actual ratios can be used for the subsequent cost reporting period.

To ensure that the distribution of outlier payments remains equitable, a LTCH's overall Medicare cost-to-charge ratio is considered not to be reasonable if:

- For discharges occurring before August 8, 2003, the value exceeds the combined (operating plus capital) upper (ceiling) and lower (floor) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. For FY 2003, the combined operating and capital upper limit is 1.421 (1.258 plus 0.163) and the combined operating and capital lower limit is 0.206 (0.194 plus 0.012) (see August 1, 2002, 67 FR 50125).

- For discharges occurring on or after August 8, 2003, the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio threshold

calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. For FY 2003, the combined (operating and capital) cost-to-charge ratio ceiling is 1.421 (1.258 plus 0.163; see August 1, 2002, 67 FR 50125). For FY 2004, the combined (operating and capital) cost-to-charge ratio ceiling is 1.366 (1.203 plus 0.163; see August 1, 2003, 68 FR 45478).

If the overall Medicare cost-to-charge ratio appears not to be reasonable, the FI should ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average.

The provider specific file contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the LTCH PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for LTCHs is to be entered in the provider specific file only in Field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

Under the LTCH PPS, an overall Medicare cost-to-charge ratio is calculated as follows:

- Medicare charges are obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data).

- Total Medicare costs are obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101).

- Divide the Medicare costs by the Medicare charges to compute an overall Medicare cost-to-charge ratio.

160 – Necessary Changes to Implement Special Add-On Payments for New Technologies

(Rev. 1, 10-01-03)
A-02-124

160.1 - Special Add-On Payments For New Technologies

(Rev. 1, 10-01-03)

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 200l, final rule (66 FR 46902), CMS established that cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or

treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, **if the total covered costs of the discharge exceed the DRG payment for the case** (including adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH) but excluding outlier payments). PRICER calculates the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for eligible cases is equal to:

- The full DRG payment (see example 1 that follows); plus
- The lesser of

    1. 50 percent of the costs of the new medical service or technology (see example 2); or

    2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment (see example 3); plus

- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

This instruction implements the above payment mechanism into the claims processing systems.

Below are three illustrative examples of this policy for cases involving an eligible technology estimated to cost $3,000 in a DRG that pays $20,000.

Example One

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $19,000. Medicare would pay $20,000, the full DRG payment. Even though the case involved a new technology eligible for add-on payments, the total covered costs of the case did not exceed the DRG payment, therefore, no additional payment is made.

Example Two:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $25,000. Because, in this case, 50 percent of the

costs of the new medical service or technology is less than 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment, Medicare would pay 50 percent of the costs of the new technology (in addition to the DRG payment). Therefore, for this case, Medicare would pay $21,500 (the DRG payment of $20,000 plus one-half of $3,000, the estimated cost of the new technology).

Example Three:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $22,000. Medicare would pay one-half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology. Therefore, for this case, Medicare would pay $21,000 (the DRG payment of $20,000 plus one-half of the costs above that amount).

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

(Rev. 1, 10-01-03)

Technologies eligible for add-on payments are identified based on the applicable codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Claims submitted with an ICD-9-CM code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers pass (if present) the "principal" and up to five "other procedure" codes to PRICER. If an eligible code is present, PRICER calculates an add-on payment if appropriate.

This adds six new fields (7 positions each) to the end of the claim data record sent to PRICER by the system maintainer.

Additionally, the National Uniform Billing Committee has approved value code 77 (FL 39-41 of the CMS-1450 or electronic equivalent) for FI use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code must be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

160.1.2 - Remittance Advice Impact

(Rev. 1, 10-01-03)

In order to process this special add-on payment for new technologies, and report in the Remittance Advice (electronic and paper), contractors:

- Use reason code 94 with group code OA in the CAS segment
- Use code ZL in the AMT segment.

- Report Code ZL in the Flat File for reporting with X12 code CS in the composite data element of the 835 PLB segment.

For PIP payment, the contractor includes only the add-on payment on a claim-by-claim basis.

170 - Billing and Processing Instructions for Religious Nonmedical Health Care Institution (RNHCI) Claims

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.1 - RNHCI Election Process

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

See Chapter 5, Section 40 of Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual for a definition of RNHCI providers. See Chapter 1, Section 130 of Pub. 100-02, Medicare Benefit Policy Manual for more information about the RNHCI benefit and coverage.

170.1.1 - Requirement for RNHCI Election

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The RNHCI benefit provides only for Part A inpatient services. For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs.

All submissions regarding RNHCI services are processed by a specialty Medicare contractor. Currently the Riverbend GBA fiscal intermediary is the specialty contractor. The completed election form must be filed with the specialty contractor and a copy retained by the RNHCI provider. See section 170.1.3 below for instructions on the submission of the election to the specialty contractor.

The RNHCI provider should question each beneficiary prior to executing the election statement to determine if the beneficiary has Medicare Part B coverage in effect via a health plan or has recently received care (services or items, including physician-ordered durable medical equipment) for which Medicare payment was sought. An affirmative answer will alert the RNHCI provider that subsequent claims under the election may be denied.

170.1.2 - Revocation of RNHCI Election

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Under §1821(b)(3), a beneficiary may revoke an election in writing or by receiving nonexcepted medical care. Once an election has been revoked, Medicare payment cannot be made to an RNHCI unless a new valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage. Multiple revocations may affect the beneficiary's ability to access the RNHCI benefit in the future (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130.2.2).

Written revocations received from a beneficiary must be filed by the RHNCI with the specialty contractor and a copy retained by the RNHCI provider. Revocations may be filed using the same format as elections, indicating a revocation in the type of bill code. See section 170.1.3 below for details.

170.1.3 - Completion of the Uniform (Institutional Provider) Bill (Form CMS-1450) Notice of Election for RNHCI

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

This form, also known as the UB-04, was developed to be suitable for submitting claims to most third party payers (both Government and private). Because it serves the needs of many payers, a particular payer may not need some data elements. Detailed information is given only for items required for the notice of election and related transactions. Items not listed need not be completed, although the RNHCI may complete them when billing multiple payers.

Elections, revocations and cancellations of elections may be submitted to the specialty contractor via the hard copy UB-04 format or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ANSI ASC X12 837 Institutional claim format) does not support the data requirements of these transactions.

Such RNHCIs complete the following data elements:

Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit

(commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction. The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit – Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D – Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the specialty contractor for processing.

Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

Required - (If available) The RNHCI enters the month, day, and year of birth numerically as MMDDCCYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000. Show the month, day, and year numerically as CCYYMMDD.

Provider Number

Required - This is the 6-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in the appropriate form locator. RNHCI provider numbers are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's HI card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient's HICN. The RNHCI enters the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, MSN, Temporary Eligibility Notice, etc., or as reported by the SSO.

170.1.4 - Common Working File (CWF) Processing of Elections, Revocations and Cancelled Elections

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

The specialty contractor submits all RNHCI election, revocations and cancelled elections to CWF for approval. The CWF will transmit a disposition 01 to notify the specialty contractor that these transactions were received and accepted. The CWF uses these records to maintain a beneficiary file of all RNHCI beneficiary elections and revocations. This file is used in processing claims for RNHCI services (see section 170.3 below) and for other Medicare services (see section 180).

CWF rejects any notices of revocations or cancellations when:

- CWF history shows no RNHCI elections are on file;
- The submitted dates do not match the elections on file;
- The revocation date is prior to the date of the election;

- The election in question has already been revoked or cancelled; or

- CWF history indicates an RNHCI claim has been processed during the election period to which the revocation or cancellation applies. If these claims were submitted in error, the RNHCI must cancel the claims prior to resubmitting the revocation or cancellation.

170.2 - Billing Process for RNHCI Services
(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

170.2.1 - When to Bill for RNHCI Services
(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

RNHCIs submit claims to the specialty contractor in the following situations:

- o At the time of beneficiary's discharge, or death.
- o At the time the beneficiary's benefits are exhausted.
- o On an interim basis monthly.

RNHCIs submit a claim even where the charges do not exceed the beneficiary's deductible. See section 40.1.1 for instructions regarding inpatient no payment billing.

170.2.2 - Required Data Elements on Claims for RNHCI Services
(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing RNHCI claims is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-04 (Form CMS-1450) hardcopy form. A table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25, §100.

Both the electronic claim transaction and the hardcopy form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP Codes are acceptable. This

information is used in connection with the Medicare provider number to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/Medicare Record Number

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

1st Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency	**Definition**
0-Nonpayment/zero claims	Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 below.
l-Admit Through Discharge Claims	Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.
2-Interim-First Claim	Use for the first of an expected series of payment bills for the same confinement or course of treatment for which Medicare utilization is chargeable.

3-Interim-Continuing Claim	Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.
4-Interim-Last Claim	Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill is the discharge date for this confinement.
7-Replacement of Prior Claim	Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

Covered Days

Required - The RNHCI must enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as non-covered, the day of discharge, and the day of death. Days must be reported using the appropriate value code.

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

Non-covered Days

Required - The RNHCI must enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Days must be reported using the appropriate value code. Non-covered days include:

- Days not falling under the guarantee of payment provision. See section 40.1. E. Occurrence code "20" (Date Guarantee of Payment Began) is used in this case;

- Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;

- Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them. Occurrence code "A3" (Benefits Exhausted) is used in this case;

- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 50.);

- Days after the date covered services ended, such as non-covered level of care;

- Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6. Occurrence span code "74" (Leave of Absence) is used in this case;

- Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;

The RNHCI must enter in "Remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for <u>each</u> category of non-covered days (e.g., "5 leave days").

Day of discharge or death is not counted as a non-covered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

Coinsurance Days

Required - The RNHCI must enter in this field the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period. Days must be reported using the appropriate value code.

Lifetime Reserve Days

Required - The RNHCI must enter the number of lifetime reserve days the beneficiary elected to use during this billing period. Days must be reported using the appropriate value code. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Patient's Name

Required - The RNHCI must enter the beneficiary's last name, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The RNHCI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

Sex

Required - The RNHCI must enter an “M” for male or an “F” for female.

Admission Date

Required - The RNHCI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

Type of Admission

Required - The RNHCI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3	Elective	The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information	Self-explanatory

Not Available

Source of Referral for Admission

Required - The RNHCI must enter the code indicating the source of this admission. The RNHCI may use any valid source of admission code that applies to the particular admission.

Patient Discharge Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period. The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may at their option enter any number of condition codes to describe conditions that apply to the billing period. There is no requirement for specific condition codes to appear on all RNHCI claims. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used.

Occurrence Codes and Dates

Conditional - The RNHCI may at their option enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence codes to appear on all RNHCI claims. Occurrence codes are 2 alphanumeric digits, and dates are shown as 6 numeric digits (MM-DD-YY).

Occurrence Span Code and Dates

Conditional - The RNHCI may at their option enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence span codes to appear on all RNHCI claims. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code. Dates are shown as 6 numeric digits (MM-DD-YY).

Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, FL 4 = 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted.

Value Codes and Amounts

Conditional - The RNHCI may at their option enter any number of value codes and related dollar amount(s) to identify data of a monetary nature necessary for the processing of this claim. There is no requirement for specific value codes to appear on all RNHCI claims. Value codes are 2 alphanumeric digits, and each value allows up to 9 numeric digits (0000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence.

Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line explains each charge. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	Description
0001	Total Charges
0120	Semi-Private Room
0270	Supplies (non-religious, as covered by Medicare)

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. The RNHCI must enter revenue code "000l". The adjacent charge entry is the sum of charges billed.

The RNHCI should list revenue codes other than revenue code “0001” in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible. To limit the number of line items on each claim, the RNHCI should sum revenue codes at the "zero" level to the extent possible.

Units of Service

Required - The RNHCI must enter the number of days for accommodations' revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a non-covered charge and you can bill the beneficiary if that is your usual practice and if the beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in non-covered charges.

Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. The last revenue code entered in revenue code "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

When submitting charges (covered/non-covered):

- Medicare is restricted by law and court order from paying for the religious portion of care or the training of personnel that provide that care. Additionally Medicare does not pay either based on charges or costs for training of nonmedical personnel. RNHCIs do not receive full Medicare payment for a beneficiary's stay since the beneficiary is fiscally responsible for the religious aspects of care. Therefore, the original Medicare or Medicare health plan rate may be significantly lower than the RNHCI private pay rate that includes religious charges.

- As medical procedures are not performed in a RNHCI, the use of high cost medical supplies are not separately payable. Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads) are not separately payable in a RNHCI. The use of diapers, incontinence pads, chux/underpads, feminine hygiene products, tissues, and the materials for simple dressings (cleansing and bandaging) are included in the daily room and board portion of the charges and should not be reported separately as supplies.

- Medical equipment (e.g., wheelchair, walker, crutches) are institution inventory items for beneficiary use in the RNHCI. The use of these items during the beneficiary stay is part of the daily interim payment to the RNHCI. To receive Medicare payment for durable medical equipment (DME) following a RNHCI stay, a beneficiary would need to meet all of the criteria, including medical necessity, and obtain a physician order or prescription. A RNHCI is not authorized as a Medicare supplier and, therefore, may not offer DME items for purchase to beneficiaries.

- Nonmedical nursing personnel, for Medicare payment purposes, perform services (e.g., serving meals, assisting with activities of daily living) that are strictly nonmedical/non-religious. The statute and court order mandates only the coverage and payment under Part A for reasonable and necessary nonmedical/non-religious care.

- Medicare payment for religious/nonmedical nursing personnel in a RNHCI, as other inpatient facilities, is a component of the per diem rate and is not separately payable.

Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff, or convenience items, that are not part of the Medicare daily interim payment rate.)

Examples of non-covered charges:

- Non-covered religious items include but are not limited to religious publications, religious recordings, any equipment for the use of those recordings, any reproduction costs for these materials, and attendance at religious meetings.

- Religious sessions with RNHCI staff or outside associates.

- Expenses related to student programs/subsistence, staff education/training, travel, or relocation to be factored into the development of charges for covered patient care services.

- Stays, items, and services that are not substantiated by appropriate documentation in the beneficiary's utilization review file or care record.

- Convenience items (e.g., telephone, computer, beautician/barber).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A supply information needed by the payer named. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

Provider Number

Required - The RNHCI must enter their National Provider Identifier (NPI).

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, the RNHCI must enter the beneficiary's Medicare Health Insurance Claim Number. The RNHCI must show the number as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause").

Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code V62.6 (defined "refusal of treatment for reasons of religion or conscience"). The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other form locators relating to medical diagnoses and medical procedures.

Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date

Required – If using the hard copy claim, an RNHCI representative makes sure the claim record is complete and accurate before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

170.3 - RNHCI Claims Processing by RNHCI Specialty Contractor

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Upon submission of a claim for RNHCI services, the specialty contractor ensures that the submission contains the complete set of required data elements according to the instructions in §170.2. The specialty contractor ensures that the submission does not contain data that is invalid, internally inconsistent or is not otherwise submitted in error.

If the submission is not found to be consistent with CMS instructions, it is returned to the RNHCI for correction.

Once the claim is found to satisfy CMS instructions, the specialty contractor ensures the claim is not a duplicate of previously paid RNHCI services or does not demonstrate grounds for Medicare denial for any other reason. If the claim appears appropriate for payment based on the specialty contractors initial processing, the claim is submitted to the CMS Common Working File (CWF) for approval.

The CWF system compares the claim submitted by the specialty contractor to the eligibility and utilization data for the beneficiary that received the services. The CWF ensures the beneficiary is eligible for Part A for the dates of service (since RNHCI services are exclusively a Part A benefit) and the beneficiary has utilization days remaining in their current inpatient spell of illness. The CWF also compares the RNHCI claim to the beneficiary's file of RNHCI elections and claims. If CWF does not identify any error conditions on the RNHCI claim, an approval message is returned to the specialty contractor.

An RNHCI claim may be rejected by CWF if:

- No RNHCI election period is present for the dates of service of the claim;
- The RNHCI election period to which the claim would apply has been revoked (see section 180 for procedures that lead to revocation of the election);
- The RNHCI election period to which the claim would apply has been cancelled; or
- The service dates on the claim overlap previously paid claims for RNCHI services or other inpatient services that were processed by a Medicare contractor other than the specialty contractor.

Claims rejected for these reasons may not be corrected and returned by the RNHCI. If the error condition can be resolved (for instance, by the resubmission of an election period cancelled in error), a new original claim for the services may be submitted by the RNHCI and processed by the specialty contractor.

Upon receipt of payment approval or rejection from CWF, the specialty contractor may then process the claim to completion. If the claim is to be paid, the specialty contractor issues a remittance subject to the Medicare payment floor and the contractor's regular payment cycle. RNHCI claims are paid a daily interim rate as established for each RNHCI provider under TEFRA payment rules (see Pub. 15-2, Provider Reimbursement Manual, chapter 30). The specialty contractor makes RNHCI payments subject to the inpatient hospital cash deductible when applicable and, if services are for the 61st through 90th day of a benefit period or are for lifetime reserve days, subject to coinsurance (see Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 3, Sections 10.1 and 10.2).

170.3.1 – Claims Not Billed to the RNHCI Specialty Contractor
(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)

Health Plans

A beneficiary covered by a Medicare Advantage plan (e.g., Medicare health maintenance organization, preferred provider organization, competitive medical plan or other health care prepayment plans.) must have prior authorization from their plan before admission to a RNHCI to assure payment for a specified time period. Continued stay reviews must be performed, submitted, and approved at designated intervals identified by the plan to assure coverage by the Medicare health plan.

In the case of billing a Medicare health plan, the RNHCI charges for inpatient services should not exceed the established interim TEFRA per diem payment amount available under Medicare Part A. The Medicare health plan may obtain the current TEFRA per diem rate information by calling the specialty contractor responsible for the involved RNHCI.

Medicaid

The State agency may obtain the current Medicare rate information by calling the specialty contractor responsible for the RNHCI.

170.4 - Informing Beneficiaries of the Results of RNHCI Claims Processing
(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. The specialty contractor uses special messages on MSNs to reflect determinations specific to the RNHCI benefit.

- If an RNHCI claim is denied because CWF did not find record of an RNHCI election in the beneficiaries record, the specialty contractor uses MSN message 42.3. This message reads: “This service is not covered since you did not elect to receive religious nonmedical health care services instead of regular Medicare services.”

- If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary’s record that had been revoked in writing, the specialty contractor uses MSN message 42.5. This message reads: “This service is not covered because you requested in writing that your election to religious nonmedical health care services be revoked.”

- If an RNHCI claim is denied because CWF found record of an RNHCI election in the beneficiary's record that had been revoked because the beneficiary received nonexcepted medical care, the specialty contractor uses MSN message 42.4. This message reads: "This service is not covered because you received medical health care services which revoked your election to religious nonmedical health care services."

170.5 - Billing and Payment of RNHCI Items and Services Furnished in the Home

(Rev. 1612; Issued: 10-03-08; Effective/Implementation Date: 01-05-09)

Medicare covers specified durable medical equipment and intermittent RNHCI nursing visits provided in the home to RNHCI beneficiaries. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130.4 regarding this policy. Medicare covers these items and services for dates of service from January 1, 2005 through December 31, 2006. Total Medicare payments under this benefit for each calendar year during this period are limited to $700,000. During this period, Medicare instructions for billing nonmedical DME by RNHCIs are as follows:

- RNHCIs must submit claims for DME and nursing visits to the RNHCI specialty FI using type of bill 43x.

- RNHCIs must submit claims for DME using revenue codes 291 (rental), 292 (purchase - new) or 293 (purchase - used) only, reporting a HCPCS code, service units, a date of service and a charge for each line item.

- RNHCIs may provide DME items as specified by a list of HCPCS codes published in Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, section 130.4.1 and distributed by their specialty contractor.

- RNHCIs must submit claims for nursing visits using revenue code 57x, reporting each visit as a separate line item using HCPCS code G0156, service units, a date of service and a charge amount.

- RNHCIs must report service units for nursing visits in increments of 15 minutes, as defined by HCPCS code G0156.

Payment to RNHCIs for DME items will be made based on the DME fee schedule. Coinsurance applies to these items. Deductible does not apply to these items. Payment to RNHCIs for nursing visits will be made at 80 percent of the national standard home health aide visit rate used under the home health prospective payment system, subject to wage index adjustment based on the location of the RNHCI facility. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, section 130.4.2 for details of the payment calculation. Coinsurance and deductible do not apply to these services.

Claims for RNHCI home services with dates of service between January 1, 2005, and December 31, 2006, will be accepted for processing subject to the timely filing instructions provided in Chapter 1.

180 - Processing Claims For Beneficiaries With RNHCI Elections by Contractors Other Than the RNHCI Specialty Intermediary

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

While elections and claims for RNHCI services are processed by a specialty contractor, all Medicare contractors (below 'non-specialty contractors') must understand the nature and purpose of the RNHCI election and the definitions of excepted and non-excepted care defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 130. Non-specialty contractors may find it advisable to have an identified specialist (or specialists) familiar with excepted and nonexcepted care used in the review of beneficiaries with RNHCI elections, since this process is so unlike other Medicare claims processes.

Beneficiaries may revoke their RNHCI election by submitting a written revocation request to Medicare, but this is rare. The specialty contractor processes these written revocations. Far more commonly, beneficiaries revoke the election simply by receiving nonexcepted medical services and requesting Medicare payment for those services. Any non-specialty contractor may receive a claim for services for a beneficiary with an RNHCI election currently in place. This section provides instructions to non-specialty contractors for the handling of such claims.

Upon receipt of a claim for payment, non-specialty contractors will not be aware that the beneficiary has an RNHCI election in place and will process the claim normally to the point of transmitting the claim to CWF. The CWF searches beneficiary records for all claims processed to determine whether an RNHCI election is found. If an election is found, CWF takes one of two actions on a claim for non-RNHCI services:

- If the claim is for DME, or orthotic/prosthetic devices, CWF will accept the DMERC claim and revoke the RNHCI election. All DMERC claims for DME, orthotic/prosthetic devices are treated as nonexcepted medical care.

- If the claim is for any other Medicare covered services, CWF initially rejects it to the non-specialty contractor. The non-specialty contractor must determine whether the care was excepted or nonexcepted. The claim must never be automatically denied. The RNHCI election revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of their Medicare coverage.

The process for non-specialty contractors to follow in responding to this CWF edit is unique among Medicare claims processes. A determination must be made whether the beneficiary's RNHCI election should be revoked. Therefore, unlike other CWF rejects which are processed in an automated fashion, claims rejected by CWF due to the presence of an RNHCI election must be suspended and developed to determine if the beneficiary received excepted care. At differing points in time, this review consisted of a request for medical records or a series of telephone contacts but these methods were found too workload intensive. In response to a

CWF reject due to the presence of an RNHCI election, non-specialty contractors must issue a simple development letter asking the provider of services to respond in a yes or no fashion to three questions:

- Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare;

- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and

- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

Each non-specialty contractor may develop the wording and format of this letter based on their experience effectively communicating with their community of providers.

The purpose for this development letter is to determine whether the care received is excepted (leaving the election intact) or whether it is nonexcepted (causing a revocation of the RNHCI election). Provider responses of 'No' to all questions in the letter will determine that the services are found to be non-excepted care. Provider responses of 'Yes' to the questions regarding inability to make beliefs known or regarding required vaccinations will determine that the services are found to be excepted care. Unless reasons to deny these claims are found during the course of claims processing, these claim will normally be paid. A provider response of 'Yes' to the question regarding the beneficiary's paying out of pocket will determine that the services are found to be excepted care, but the claim for payment for medical care must be denied. The claim must be denied because the beneficiary has not made a request for Medicare payment. The beneficiary has accepted liability for these services in order to protect their RNHCI election.

Once the non-specialty contractor makes this determination of whether the care is excepted or nonexcepted, the claim record is annotated accordingly (see section 180.1 below) and returned to CWF. The claim will be approved for payment and if the care was found to be nonexcepted CWF will cause the beneficiary's RNHCI election to be revoked.

In the event that the provider does not reply timely to the development letter, non-specialty contractors must make an excepted/nonexcepted determination based on the evidence presented by the claim itself. Non-specialty contractors shall apply the same timeliness standard to these responses as to all other documentation requests. If the claim contains durable medical equipment or prosthetic/orthotic devices, the non-specialty contractor may make a determination of nonexcepted care on that basis alone. All such claims are treated as nonexcepted care. For all other claims, non-specialty contractor staff with a clinical background must make their best determination based on the diagnoses and procedures reported on the claim whether the services were excepted or nonexcepted care. In cases where the determination cannot be made with certainty but there is some reason to suspect services were nonexcepted care, the non-specialty contractor shall make a determination of nonexcepted care and annotate the claim record accordingly.

Determinations must be made within the earlier of 30 days of receipt of the provider's response or 30 days of the end of the timely response period.

The importance of the development of these claims lies in its effect on the beneficiary. If the claim for medical care is denied improperly based on the presence of the RNHCI election, the beneficiary will incur liability in error and may experience financial hardship. Similarly, it is important that the review result in accurate determinations of nonexcepted care since repeated revocations of this benefit can have an impact on the beneficiary's right to access the RNHCI benefit in the future.

180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Once the excepted/nonexcepted care determination is made, the non-specialty contractor resubmits the claim to CWF using the following indicators to record the determination:

- Indicator "1" - for excepted care; or
- Indicator "2" - for nonexcepted care.

NOTE: Indicator 0 (zero) presents no entry.

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

Record	Location	Field	Size
HUIP	84	1	823
(IP hospital/SNF Claim)			
HUOP	64	1	778
(Outpatient)			
HUHC	64	1	778
(Hospice)			
HUHH	64	1	778
(Home Health)			
HUBC	13	1	57
(Carrier/Part B Claim)			

The screen field corresponding to these CWF fields may vary depending on the Medicare shared system in use at a contractor's location. Non-specialty contractors may contact their shared system maintainer if necessary to determine the correct screen location to use for excepted/nonexcepted care indicators.

If a claim is resubmitted with a "0" excepted care indicator in error, CWF will again reject the claim. Upon receipt of the resubmitted claim with a valid "1" or "2" entry, CWF will approve it for payment (by generating a disposition "01") and revoke the beneficiary's

election if the care received was nonexcepted. CWF will **not** notify either the specialty contractor or the non-specialty contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims processed at the specialty contractor will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.

Once the excepted/nonexcepted care determination is made, the non-specialty contractor annotates the claim and the associated remittance advice with the following indicators to record the determination:

If development to make the excepted/nonexcepted care determination discovered that the beneficiary paid out of pocket for the services and the claim for payment for medical care must be denied as a result, annotate the claim and the associated remittance advice with the following codes:

- Claim adjustment reason code 125, defined "Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate."

- Remittance advice remark code MA47, defined "Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment."

180.2 - Informing Beneficiaries of the Results of Excepted/Nonexcepted Care Determinations by the Non-specialty Contractor

(Rev. 851, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

Beneficiaries are informed of all Medicare payment determinations, including those for RNHCI services, via their monthly Medicare Summary Notice (MSN). The complete set of messages used on the MSN can be found in chapter 21, section 50.42 of this manual. Non-specialty contractors use special messages on MSNs to reflect determinations specific to excepted or nonexcepted care.

- If a determination of excepted care is made, the non-specialty contractor uses MSN message 42.1. This message reads: "You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care."

- If a determination of nonexcepted care is made, the non-specialty contractor uses MSN message 42.2. This message reads: "Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services has been revoked for these services unless you file a new election."

If development to make the excepted/nonexcepted care determination discovered that the beneficiary did not request Medicare payment, but instead paid for the services out of pocket, the non-specialty contractor uses MSN message 16.41. This message reads: "Payment is being denied because you refused to request reimbursement under your Medicare benefits."

190 - Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.1 - Background

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

This section and its subsections provide instructions about the IPF PPS. The IPF PPS replaces existing reasonable cost-based payments subject to Tax Equity and Fiscal Responsibility Act (TEFRA) limits under section 1886 (b) of the Social Security Act (the Act) for discharges occurring on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at 42 CFR 412, Subpart N, provides payment for inpatient psychiatric treatment when provided to an inpatient in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs).

190.2 - Statutory Requirements

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary—-(1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub.L. 108-173), section 405(g) extended the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

190.3 - Affected Medicare Providers

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Psychiatric hospitals and distinct part psychiatric units of acute care hospitals and CAHs are included in the IPF PPS and are referred to in these instructions as "inpatient

psychiatric facilities" or "IPFs." The regulations at 42 CFR 412.402 define an IPF as a hospital that meets the requirements specified in 42 CFR 412.22, 42 CFR 412.23(a), 42 CFR 482.60, 42 CFR 482.61, and 42 CFR 482.62, and units that meet the requirements specified in 42 CFR 412.22, 42 CFR 412.25, and 42 CFR 412.27.

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to mentally ill patients, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and staffing requirements in 42 CFR 412.27 which mirror the requirements for a psychiatric hospitals in 42 CFR 482.60, 42 CFR 482.61 and 42 CFR 482.62.

The provider number ranges (OSCAR number) for IPFs are from xx-4000 through xx-4499, xx-Sxxx, and xx-Mxxx. Note that this will change with the implementation of National Provider Identifiers (NPI).

The following hospitals are not paid under the IPF PPS:

- Veterans Administration hospitals; See 42 CFR 412.22 (c).

- Hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403; Psychiatric Hospitals (provider numbers xx-4000 - xx-4499) in the State of Maryland are paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital in Maryland identified by 'S' in the third position of the OSCAR number are waived from the IPF PPS, as is the acute hospital in which they are located. Currently there are no CAHs in Maryland.

- Hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Pub. L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub. L. 92-603 (42 U. S. C. 1395b-1); See 42 CFR 412.22 (c). IPFs in acute care hospitals that participate in demonstration projects are paid in accordance with the demonstration project;

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are paid in accordance with 42 CFR 412. 22 (c).

- Payment to foreign hospitals is made in accordance with the provisions set forth in 42 CFR 413.74.

190.4 - Federal Per Diem Base Rate

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Payments to IPFs under the IPF PPS are based on a single Federal per diem base rate computed from both the inpatient operating and capital-related costs of IPFs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct graduate medical education, and nursing and allied health education).

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate (which is broken into a labor-related share and a non-labor-related share) and applicable patient and facility adjustments that are described in §§190.5 and 190.6.

The standardized Federal per diem base rates and adjustment factors are updated July 1 every year, beginning July 1, 2006. For the updated standardized Federal per diem base rates for subsequent years refer to the **Federal Register** rules and accompanying Recurring Update Notifications. See http://www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp

190.4.1 - Standardization Factor

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The CMS standardized the IPF PPS Federal per diem base rate in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, CMS compared the IPF PPS payment amounts calculated from the FY 2002 MedPAR file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. CMS then applied this factor to the average per diem cost of an IPF stay.

190.4.2 - Budget Neutrality

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The BBRA required that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented. Therefore, in the November 2004 IPF PPS final rule, CMS calculated the budget neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented. CMS calculated the final Federal per diem base rate to be budget neutral during the implementation period under the IPF PPS using a July 1 update cycle. The implementation period for the IPF PPS is the 18-month period of January 1, 2005 through June 30, 2006.

190.4.2.1 - Budget Neutrality Components

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The following are the three components of the budget neutrality adjustment:

(1) Outlier Adjustment: Since the IPF PPS payment amount for each stay includes applicable outlier amounts, CMS reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The appropriate outlier amount was determined by comparing the adjusted prospective payment for the entire stay to the computed cost per case. If costs were above the prospective payment plus the adjusted fixed dollar loss threshold amount, an outlier payment was computed using the applicable risk-sharing percentages. The outlier adjustment was calculated to be 2 percent of total IPF PPS. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments;

(2) Stop-Loss Adjustment: CMS provides a stop-loss payment to ensure that an IPF's total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. CMS reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments. Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. The CMS has previously stated that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition. Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39 percent.

(3) Behavioral Offset: The implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may incur higher payments than assumed in the calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, CMS reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes.

190.4.3 - Annual Update

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS is on a July 1st – June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006, and will occur every July 1 thereafter.

In accordance with 42 CFR 412.428, the annual update includes revisions to the Federal per diem base rate, the hospital wage index, ICD-9-CM coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) rate, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

190.4.4 - Calculating the Federal Payment Rate

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

To calculate an IPF PPS payment, follow the steps below:

1 - Multiply the Federal per diem base rate by the labor share.

2 - Multiply the resulting amount by the appropriate wage index factor.

3 - Multiply the Federal per diem base rate by the non-labor share.

4 - Multiply the resulting amount from this by any applicable cost-of-living adjustment (COLA) (Alaska or Hawaii).

5 - Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate (Add the results of steps 2 and 4). This is the Federal rate.

You must multiply this sum (step 5) by the all applicable facility and patient level adjustment factors described in §§190.5 and 190.6, to calculate the final payment.

CMS furnishes and maintains a PRICER program for intermediaries, and provides a PC PRICER that may be downloaded from the CMS Web site. The Web site is www.cms.hhs.gov/pcPricer

190.5 - Patient-Level Adjustments

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Patient-level adjustments include a DRG, or MS-DRG, adjustment, comorbidity adjustment, an age adjustment, and a variable per diem adjustment.

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

On claims with discharges before October 1, 2007, the IPF PPS provides adjustments for 15 designated DRGs. On claims with discharges on or after October 1, 2007, the IPF PPS provides adjustments for 17 designated MS-DRGs. Payment is made under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG/MS-DRG will receive the DRG adjustment in addition to all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the following psychiatric DRGs/MS-DRGs, the IPF will receive the Federal per diem base rate and all other applicable adjustments.

IPFs must submit claims providing the ICD-9-CM code of the principal diagnosis. To classify the case to the appropriate DRG/MS-DRG, the GROUPER software for the hospital IPPS is used and the IPF PRICER applies the appropriate adjustment factor to the Federal per diem base rate.

Changes to the ICD-9-CM coding system are addressed annually in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information. Further information concerning the Official Version of the ICD-9-CM can be found in the IPPS final regulation.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS-DRGs which were effective October 1, 2007:

(v24) DRG Prior to 10/01/07	(v25) MS-DRG From 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896	Alcohol/drug abuse or dependence w/o	0.88

		rehabilitation therapy w MCC	
	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	

190.5.2 - Application of Code First

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

According to the ICD-9-CM Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable ICD-9-CM coding convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches the secondary codes for a psychiatric code to assign the DRG/MS-DRG in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.

The most current Code First list is posted on the IPF PPS Web site at www.cms.hhs.gov/InpatientPsychFacilPPS

Code First Example

Diagnosis code 294.11 "Dementia in Conditions Classified Elsewhere with Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

Four digit code 294.1 "Dementia in Conditions Classified Elsewhere", is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 "Persistent Mental Disorders Due to Conditions Classified Elsewhere" appears in the ICD-9-CM as follows:

294 PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

Alzheimer's disease (331.0)

Cerebral lipidosis (330.1)

Dementia with Lewy bodies (331.82)

Dementia with Parkinsonism (331.81)

Epilepsy (345.0 – 345.9)

Frontal dementia (331.19)

Frontotemporal dementia (331.19)

General paresis [syphilis] (094.1)

Hepatolenticular degeneration (275.1)

Huntington's chorea (333.4)

Jacob-Creutzfeldt disease (046.1)

Multiple sclerosis (340)

Pick's disease of the brain (331.11)

Polyarteritis nodosa (446.0)

Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's Chorea" as the principal diagnosis code and 294.11 "Dementia In Conditions Classified Elsewhere With Behavioral Disturbances" as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs, or 17 MS-DRGs, for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG/MS-DRG, the PRICER would search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.

190.5.3 - Comorbidity Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and not reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay or affect both

treatment and the length of stay. IPFs enter the full ICD-9-CM codes for up to eight additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has 17 comorbidity categories, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-9-CM codes that are associated with each category is on the IPF PPS Web site at www.cms.hhs.gov/inpatientpsychfacilpps .

The 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	**Adjustment Factor**
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	1.13
Eating and Conduct Disorders	1.12
Infectious Disease	1.07
Drug and/or Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings - Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

190.5.4 - Age Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS has an age adjustment with 9 age categories; under 45, over 80, and categories in 5 year groupings in between. IPFs receive this adjustment for each day of the stay. The age adjustment is determined based on the age at admission and does not change regardless of the length of stay.

Age	Adjustment Factor
Under 45	1.00
45 and under 50	1.01
50 and under 55	1.02
55 and under 60	1.04
60 and under 65	1.07
65 and under 70	1.10
70 and under 75	1.13
75 and under 80	1.15
80 and over	1.17

190.5.5 - Variable Per Diem Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The variable per diem adjustments account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. The variable per diem adjustments decline each day of the patient's stay through day 21. After day 21, the adjustments remain the same each day for the remainder of the stay.

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 1 - Facility Without a Qualifying Emergency Department	1.19
Day 1 - Facility With a Qualifying Emergency Department	1.31
Day 2	1.12
Day 3	1.08
Day 4	1.05
Day 5	1.04
Day 6	1.02
Day 7	1.01
Day 8	1.01
Day 9	1.00

Day-of-Stay	Variable Per Diem Payment Adjustment*
Day 10	1.00
Day 11	0.99
Day 12	0.99
Day 13	0.99
Day 14	0.99
Day 15	0.98
Day 16	0.97
Day 17	0.97
Day 18	0.96
Day 19	0.95
Day 20	0.95
Day 21	0.95
Over 21	0.92

*The adjustment for day 1 would be 1.31 or 1.19 depending on whether the IPF has a qualifying emergency department or is a psychiatric unit in an acute care hospital or CAH with a qualifying emergency department (see §190.6.4).

190.6 - Facility-Level Adjustments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Facility-level adjustments include the hospital wage index, a rural location adjustment, a teaching status adjustment, an emergency department adjustment for qualifying EDs, and a cost-of-living adjustment for IPFs located in Alaska and Hawaii.

190.6.1 - Wage Index

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The wage index accounts for the geographic differences in labor costs. The IPF PPS uses the unadjusted, pre-floor, pre-reclassified hospital wage index in effect on July 1 of each year. The wage index is applied to the labor-related share of the Federal per diem base rate.

Core-Based Statistical Area (CBSA) designations are used for assigning a wage index value for discharges occurring on or after July 1, 2006. Updates to the IPF PPS wage index are made in a budget neutral manner. CMS calculates a budget-neutral wage index adjustment factor by comparing estimated payments under the previous wage index to estimated payments under the updated wage index. This factor is applied in the update to the Federal per diem base rate.

190.6.2 - Rural Location Adjustment
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There is a 17 percent adjustment if a facility is located in a rural area. The IPF PPS defines urban and rural areas at 42 CFR 412.402.

190.6.3 - Teaching Status Adjustment
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs that train interns and residents receive a facility-level adjustment to the Federal per diem base rate. The cost of direct graduate medical education (DGME) and nursing and allied health education are not paid through the IPF PPS.

PRICER calculates the adjustment by adding 1 to the ratio of interns and residents to the average daily census (ADC), and then raising that sum to the 0.5150 power.

The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to November 15, 2004. (See §190.6.3.1 for more detailed instructions for the FTE Resident Cap).

For beneficiaries enrolled in a Medicare Advantage plan, IPFs may bill for DGME and nursing and allied health education costs. There is no authority to pay teaching status adjustment to IPFs for Medicare Advantage beneficiaries, as is done under the IPPS.

190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)
There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. There is no limit to the number of residents teaching institutions can hire or train. There is only a limit to the number of residents who may be counted in calculation of the IPF PPS teaching adjustment. The cap is the number of FTE residents that trained in the IPF during a base year.

An IPF's FTE resident cap is determined based on the IPF's most recently filed cost report, filed prior to November 15, 2004. IPFs that first began training residents after November 15, 2004, will initially receive an FTE cap of zero. The FTE caps for new IPFs (as well as existing IPFs) that start training residents in a new DGME program (as defined in 42 CFR 413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in 42 CFR 412.424(d)(1)(iii)(B)(2)).

IPFs are not permitted to aggregate the FTE resident caps used to compute the IPF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IPF (for example, a resident on a full-time, 3-month rotation to the IPF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time

counted for purposes of the IPPS Indirect Medical Education (IME) adjustment is allowed to be counted for purposes of the teaching status adjustment under the IPF PPS.

The denominator used to calculate the teaching status adjustment under the IPF PPS is the IPF's ADC from the current cost reporting period. If IPFs have more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If an IPF were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility trains).

190.6.3.2 - Reconciliation of Teaching Adjustment on Cost Report

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The teaching status adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount based on information from the cost report are adjusted through lump sum payments/recoupments when the cost report is settled.

The teaching adjustment is calculated as follows:

1. Determine the product of the wage-adjusted Federal per diem base rate and the applicable teaching, rural, DRG, comorbidity, and age adjustments.

2. Determine the product of the wage adjusted base rate and the applicable rural, DRG, comorbidity, and age adjustments.

3. Determine the difference of these two products (Step 1 minus Step 2).

4. Calculate and sum the variable per diem amounts for the product in Step 2 to calculate the Federal payment net of the teaching adjustment amount.

5. Calculate and sum the variable per diem amounts for the difference in Step 3 to calculate the portion of the Federal payment attributable to the teaching adjustment.

6. To obtain the total Federal payment necessary for outlier calculations, etc., add Steps 4 and 5 together. Step 5 alone is the teaching adjustment portion of the Federal payment, and can be separately identified and reconciled on the cost report.

190.6.4 - Emergency Department (ED) Adjustment

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

An adjustment is provided for IPFs that maintain a qualifying ED. This is a facility-level adjustment that applies to all IPF admissions (with the one exception described below),

regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive a 31 percent adjustment as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 19 percent adjustment as the variable per diem adjustment for day 1 of each patient stay.

A qualifying ED means an ED of psychiatric units located in a hospital or CAH with EDs that are staffed and equipped to furnish a comprehensive array (medical as well as psychiatric) of emergency services and meets the definition of "provider-based status" (42 CFR 413.65) and meets the definition of a "dedicated emergency department" (42 CFR 489.24).

- "Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of this section." 42 CFR 413.65

- "Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

  (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

  (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

  (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." See 42 CFR 489.24.

As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF.

IPFs should notify their Medicare contractors 30 days before the beginning of their cost reporting period regarding if they have a qualifying ED. Medicare contractors have the discretion to determine how they wish to be notified and the documentation they require. Once the Medicare contractor is satisfied that the IPF has a qualifying ED, the Medicare contractor should enter the information in the provider-specific file within a reasonable timeframe so that the IPF can begin to receive the ED adjustment. Application of the ED adjustment is prospective.

Medicare contractors may also use the date the documentation was received from the IPF to implement the ED adjustment. The provider-specific file can be updated from the date of the attestation and claims processed from that date will receive the ED adjustment. CMS does not intend that IPFs would have to wait until the beginning of their next cost report period to receive the ED adjustment.

However, if an IPF no longer meets the definition of a qualified ED, the IPF must promptly notify their Medicare contractor. The Medicare contractor would immediately remove the flag from the provider-specific file and the provider will not receive the ED adjustment. If the provider should once again meet the definition of a qualified ED, they should contact their Medicare contractor immediately in order to update their file.

190.6.4.1 - Source of Admission for IPF PPS Claims for Payment of ED Adjustment

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Source of admission code "D" is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital or CAH. Claims with source of admission code "D" do not receive the ED adjustment.

See Pub. 100-04, Medicare Claims Processing Manual chapter 25, §60.1, FL 20 for additional instructions for completing the CMS-1450 data set.

190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. An adjustment for IPFs located in Alaska and Hawaii is made by multiplying the non-labor related share of the Federal per diem base rate and ECT rate by the applicable COLA factor.

The CMS notes that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR §591.207, the OPM established the following COLA areas:

(a) City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(b) City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(c) City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse;

(d) Rest of the State of Alaska.

In the November 2004 and May 2006 IPF PPS final rules, the CMS showed only one COLA for Alaska because all four areas were the same amount (1.25). Effective September 1, 2006, the OPM updated the COLA amounts and there are now two different amounts for the Alaska COLA areas (1.24 and 1.25).

	Location	COLA
Alaska	Anchorage	1.24
	Fairbanks	1.24
	Juneau	1.24
	Rest of Alaska	1.25
Hawaii	Honolulu County	1.25
	Hawaii County	1.17
	Kauai County	1.25
	Maui County	1.25
	Kalawao County	1.25

190.7 - Other Payment Policies

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.7.1 - Interrupted Stays

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay. Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for an outlier payment. In other words, an interrupted stay is treated as one stay and one discharge for the purpose of payment. Thus, the IPF should hold the claim for 3 days to ensure there is not a readmission that soon. In this way, the readmission is included on the original claim.

For example, if a patient leaves the IPF on 1/1 and returns to the same IPF on 1/3, this is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills are allowed.

In the case where an IPF patient is discharged from IPF "A" and within 3 days is readmitted to IPF "B," and IPF "B" does not know about the patient's immediately preceding hospitalization in IPF "A," then 2 bills are allowed.

Medicare contractors should monitor trends to ensure IPFs are not consistently admitting, discharging, and readmitting patients in order to receive the larger variable per diem payments associated with the first days of a patient's stay.

190.7.2 - Outlier Policy

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Additional payments are made for those cases that have extraordinarily high costs. If the estimated cost of the case is greater than the adjusted fixed dollar loss threshold amount (the fixed dollar loss threshold amount multiplied by area wage index, rural location, teaching and COLA), an additional payment is added to the IPF PPS payment amount.

The fixed dollar loss threshold amount is computed so that projected outlier payments are equal to 2 percent of total IPF PPS payments to ensure that IPFs treating unusually costly cases do not incur substantial losses and promote access to IPFs for patients who require expensive care.

Once the threshold amount is met, CMS will share a declining percentage of the losses for a high cost case. The risk-sharing percentages would be 80 percent of the difference between the cost for the case minus payment and the adjusted threshold amount for days 1 through 9 of the stay and 60 percent of the difference after the 9th day. Medicare contractors will determine the total outlier amount and divide by the number of days, then pay 80 percent for days 1-9 and 60 percent for days beyond that.

Outlier payments are not paid on interim bills, but they are calculated on a final discharge bill, a benefits exhaust bill, or if the patient falls below a covered level of care.

190.7.2.1 - How to Calculate Outlier Payments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

1 - Calculate the Adjusted Fixed Dollar Loss Threshold Amount

- Multiply the threshold amount by the labor share and the area wage index;
- Multiply the threshold amount by the non-labor share and any applicable COLA (Alaska or Hawaii);

- Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural); and

- Add this amount to the sum of the Federal per diem payment and ECT payment to obtain the adjusted threshold amount.

2 - Calculate Eligible Outlier Costs

- Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.
- Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.
- Divide this amount by the length of stay to calculate the per diem outlier amount.
- For days 1 through 9, multiply this per diem outlier amount by 0.80. For day 10 and thereafter, multiply the per diem outlier amount by 0.60. The sum of these amounts is the total outlier payment.

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS outlier methodology requires the Medicare contractor to calculate the provider's overall Medicare cost-to-charge ratio using the facility's latest settled cost report or tentatively settled cost report (whichever is from the later period), and associated data. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals, Medicare charges are obtained from Worksheet D-4, column 2, lines 25 through 30, plus line 103 from the cost report. Total Medicare costs are obtained from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).

Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

Distinct Part Units

For IPFs that are distinct part psychiatric units, total Medicare charges are obtained from the Provider Statistical and Reimbursement Report (PS&R) associated with the applicable cost report. If the PS&R data is not available, the following method is used:

All references to Worksheets and specific line numbers should correspond with the sub-provider identified as the IPF unit that has the letter "S" or “M” in the third position of the Medicare provider number.

- Estimate Medicare routine charges by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6.

- Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at the total Medicare charges.

- To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101)

- Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket and wage budget neutrality factor. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

In order to receive the payment, an IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with 42 CFR 412.404(d)(3), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers.

190.7.4 - Stop Loss Provision (Transition Period Only)

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

The IPF PPS includes a stop-loss provision during the 3-year transition. The purpose is to ensure each facility receives an average payment per case under the IPF PPS that is no less than 70 percent of its average payment under the TEFRA. It is calculated at cost report settlement. New providers are not eligible for stop-loss payments. See §190.9.1.

Example of stop-loss calculation in year 3 of the transition:

1. Enter Total (100%) TEFRA payments for cases during cost reporting period

2. Enter Total (100%) PPS payments for cases during cost reporting period

3. Multiply Step 1 by 0.70.

4. If Step 3 is greater than Step 2, subtract Step 2 from Step 3. Otherwise, enter 0.

5. Add Steps 2 and 4 to calculate total PPS payments.

6. Multiply Step 1 by 0.25 to calculate the TEFRA portion.

7. Multiply Step 5 by 0.75 to calculate the PPS portion.

8. Add Steps 6 and 7 to calculate the IPF's aggregate payments in the third year of the IPF PPS. Determine if this amount is at least 70 percent of what would have been paid under TEFRA, then pay the difference.

NOTE: Since the transition will be completed for RY 2009, for cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent PPS and, therefore, the stop loss provision will no longer be applicable. The CMS has previously stated that we would remove this 0.39 percent adjustment to the Federal per diem base rate after the transition. Therefore, for RY 2009, the Federal per diem base rate and ECT rates will be increased by 0.39 percent.

190.8 - Transition (Phase-In Implementation)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.8.1 - Implementation Date for Provider

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS is phased-in over 3 years from the cost based reimbursement to the Federal prospective payment. All IPF providers must transition over the 3-year transition period. There is no election of 100 percent PPS in the first year.

During the transition period, payment is based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPF's TEFRA-based reimbursement rate for each case as follows:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

The 3-year transition period is separate from the annual update cycle of the IPF PPS. The transition is effective according to cost reporting periods, but the updates to the rates take effect July 1 of each year. For more detailed information regarding the annual update cycle, refer to §190.4.3-Annual Update.

Although the IPF PPS is effective January 1, 2005, an individual IPF's PPS transition year start date is the first day of the first cost reporting period that begins on or after that date. An IPF may begin the IPF PPS as early as January 1, 2005, or as late as December 31, 2005, should a cost reporting period begin on that date.

The IPF PPS applies to claims for discharges occurring in the IPF's first cost reporting period beginning on or after January 1, 2005. Where the IPF has already billed interim claims for an inpatient that has benefit days remaining after the PPS implementation date, the provider must submit a cancel bill and re-bill under the IPF PPS so that payment for the entire stay is made under the IPF PPS.

If the provider ever had a TEFRA limit, the IPF is not a new provider and therefore will receive the blended payment. This includes those providers that previously closed their psychiatric units and then re-opened the psychiatric units. If the provider had a TEFRA limit established, that TEFRA limit is updated using the rate of increase percentages in 42 CFR 413.40.

For cost reporting periods beginning in FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket increase percentage minus a factor based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recently available cost reporting period.

To update the TEFRA limit for IPFs that were closed during FY 1999 through FY 2002 and then re-opened (including CAHs that were statutorily precluded from having a distinct part unit), the rate-of-increase for these years would be the full market basket up to the cap on the target amounts.

190.9 - Definition of New IPF Providers Versus TEFRA Providers
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.9.1 - New Providers Defined
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A new IPF provider is one that meets the definition of an IPF in 42 CFR 412.402, and under present or previous ownership or both, has not received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005. To be a new provider, the first cost reporting period as a psychiatric hospital, a distinct part unit in an acute care hospital or a CAH must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.

Change of ownership has no impact on whether an IPF is considered a new IPF provider.

190.10 - Claims Processing Requirements Under IPF PPS
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.10.1 - General Rules
(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must code diagnoses correctly; using ICD-9-CM codes for the principal diagnosis, and up to eight additional diagnoses, if applicable;
- The IPF must code procedures correctly using ICD-9-CM Volume III codes for one principal procedure and up to five additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and
- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date (or effective December 3, 2007, benefits exhaust date, if present) on the claim will determine the DRG/MS-DRG assignment.

190.10.2 - Billing Period

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

When the patient has Medicare benefits, IPF providers will submit one admit through discharge claim for the stay upon discharge. IPFs may interim bill in 60-day intervals following the instructions in chapter 1, §50.2 of this manual should the patient's stay be exceptionally long. Final PPS payment is based upon the date of physical discharge or death, or the date benefits exhausted (effective December 3, 2007).

IPFs can submit adjustment claims, but late charge claims will not be allowed, e.g., the adjustment claim must include all charges and services and must replace the earlier claim(s) instead of including only the additional charges and services.

In situations when a patient falls below a skilled level of care, IPFs should submit a 112 TOB with both an Occurrence Code 22 (Date active care ended) and patient status code 30 (Still a patient). IPFs should then continue to submit subsequent interim 117 TOBs, as appropriate, with the patient status code 30 and the correct Occurrence Span Codes that identify payment liability (codes 76 or 77).

Effective December 3, 2007, once the patient's Medicare benefit's exhaust, the IPF is allowed to submit no-pay bills (TOB 110), with a Patient Status Code of 30 every 60 days, until the patient is physically discharged or dies. The last bill shall contain a discharge patient status code. IPFs no longer need to continually adjust claims once benefits exhaust.

190.10.3 - Patient Status Coding

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

All patient status (i.e., discharge disposition) codes for 11X TOB are valid, but there are no special payment policies related to transfer codes; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with Condition Code 40) are applicable under IPF PPS.

190.10.4 - Reporting ECT Treatments

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs must report on their claims under Revenue Code 0901, along with the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Providers will code ICD-9-CM procedure code 94.27 in the procedure code field

and for the procedure date will use the date of the last ECT treatment the patient received during their IPF stay.

190.10.5 - Outpatient Services Treated as Inpatient Services
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs are subject to the 1-day payment window for outpatient bundling rules. Refer to chapter 3, §40.3 of this manual for more information on bundling rules.

190.10.6 - Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The payer at the time of the patient's admission to an IPF is responsible for the cost of the entire stay. This could occur for patients who move from traditional Medicare to a Medicare Advantage plan or vice versa.

190.10.7 - Billing for Interrupted Stays
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs shall bill for the interrupted stay using Occurrence Span Code 74. The Occurrence Span Code FROM date equals the day of discharge for the IPF and the THROUGH date is the last day the patient was not present in the IPF at midnight. For example, the patient leaves the IPF on 1/1 and returns to the IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 - 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed. The accommodation Revenue Code 018X (RT 50, field 5), (SV 201), (leave of absence) will continue to be used in the current manner in terms of Occurrence Span Code 74 (RT 40, field 22 – 27) and date range.

190.10.8 - Grace Days
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no grace days allowed under IPF PPS, therefore the date the beneficiary is notified of the provider's intent to bill (Occurrence Code 31) is the last covered day for that patient.

190.10.9 - Billing Stays Prior to and Discharge After PPS Implementation Date
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under IPF PPS, payment to the facility is based on IPF PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (see chapter 1, §50.2 of this manual). If the facility

submitted multiple interim bills, the facility will need to submit cancels for all bills and then re-bill once the cancels are accepted.

Exceptions:

If the beneficiary's benefits were exhausted or the beneficiary is in a non-covered level of care prior to implementation of IPF PPS, then IPF PPS is not applicable and the IPF will continue to submit no-pay bills (TOB 110) to Medicare.

190.10.10 - Billing Ancillary Services Under IPF PPS
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no special rules for billing IPF inpatient ancillary services.

190.10.11 - Covered Costs Not Included in IPF PPS Amount
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The following covered services are not included in the IPF PPS discharge payment amount:

- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS.

- DGME and bad debts.

190.10.12 - Same Day Transfer Claims
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A same day transfer occurs when a patient is admitted to an IPF and is subsequently transferred for acute care (or another type of inpatient facility care) on the same day. If the patient is admitted to an IPF with the expectation that the patient will remain overnight, but is discharged before midnight, the day is counted as a full day for the cost report, but is not counted as a Medicare covered day for purposes of charging the beneficiary utilization.

IPFs should show the same day for admission and discharge, and report Condition Code 40 (Same Day Transfer).

If the patient is admitted to an IPF and discharged (not transferred to another inpatient setting) the same day before midnight, the day is counted as a full day for the cost report, and is counted as a Medicare covered day for purposes of charging the beneficiary utilization. IPFs do not report Condition Code 40 on this case.

The purpose for the variance in coding is to charge the beneficiary only 1 day utilization where two facilities are billing. Payment will be made for 1 day.

190.10.13 - Remittance Advice - Reserved
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Not yet available.

190.10.14 - Medicare Summary Notices and Explanation of Medicare Benefits
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Existing notices for inpatient hospital PPS are used.

190.11 - Benefit Application and Limits-190 Days
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per 42 CFR 409.62. The 190-lifetime limitation does not apply to psychiatric certified distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

The Benefit Period provisions described in Medicare Publication 100-01, Medicare General Information, Eligibility, and Entitlement, chapter 3, §§10.4-10.4.4 are applicable to inpatients in either a freestanding psychiatric hospital or a distinct part.

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. This limitation applies only to services furnished in a psychiatric hospital. This limitation does not apply to inpatient psychiatric services furnished in a hospital, a CAH or distinct part psychiatric unit. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

The CWF keeps track of days paid for inpatient psychiatric services and informs the Medicare contractor on claims where the 190-day limit is reached.

For a more detailed description see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §30.C. and chapter 4, §50 for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services. For details concerning the pre-entitlement inpatient psychiatric benefit reduction provision see Pub. 100-02, Medicare Benefit Policy Manual, chapter 4, §§10 - 50.

190.12 - Beneficiary Liability
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system. An IPF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

An IPF receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least 1 covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under 42 CFR 409.82, 42 CFR 409.83, and 42 CFR 409.87 and for items or services as specified under 42 CFR 489.30.

For more detailed information regarding lifetime reserve days, refer to Pub. 100-02 Medicare Benefit Policy Manual, chapter 5.

190.12.1 - Benefits Exhaust

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Effective December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust and the date benefits exhaust (if present) will substitute for the 'actual' discharge date. The claim is paid based on the benefits exhaust date if present rather than the discharge date. The Pricer version used to price claims for the discharge is when the services actually were provided (i.e., when the Medicare beneficiary has Medicare benefits). No pay/110 TOBs are allowed instead of continually adjusting the claims (117 TOB) until actual discharge occurs once benefits exhaust.

Under TEFRA, the PS&R report used the benefits exhaust date as the discharge date (if present). This changed when the IPF PPS was implemented, and the 'actual' discharge date was used. The days stay with the year they occurred, making it easier for the PS&R report (especially during the blend period) to settle the cost report. This means that:

1. Claims will now be settled on the appropriate cost report;

2. The appropriate PPS-TEFRA blend percentage will be paid;

3. Patients with long lengths of stay will be counted on the correct PS&R report;

4. The PRICER version used will be the one in effect at the time the services were provided (i.e., when the Medicare beneficiary actually has Medicare benefits).

190.13 - Periodic Interim Payments (PIP)

(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Medicare contractors shall pay PIP for providers who send a request to their Medicare contractor and qualify. Outlier payments, teaching adjustment, and ECT add-on payments are not included in the PIP payment amount but are paid on the discharge claim for ECT,

and on a discharge, benefits exhaust, or last day of a Medicare covered level of care claim, for the teaching adjustment and outlier payment.

190.14 - Intermediary Benefit Payment Report (IBPR)
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IBPR report has been changed to reflect the payments for IPFs going to PPS psychiatric hospitals and units.

190.15 - Monitoring Implementation of IPF PPS Through Pulse
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The FISS 620A and 620B reports will be modified to add an additional row for IPF monitoring. The report will be modified to include a separate reporting line titled "IPF PPS." This entry will appear immediately below "IPF PPS" and report the total claim count and total reimbursement amount. IPF PPS totals will include all providers with the last four digits of the provider numbers in range 4000 – 4499, xx-Sxxx, and xx-Mxxx.

190.16 - IPF PPS System Edits
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines, and

- the length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

CWF shall ensure that Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the IPF within 3 days).

NOTE: Information regarding the claim form locators that correspond with occurrence span codes and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

190.17 - IPF PPS PRICER Software
(Rev. 1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

CMS has developed an IPF PRICER program that calculates the Medicare payment rate. PRICER software will be electronically supplied to the Standard Systems. A Personal Computer (PC) version of this PRICER will be available on the CMS Web site in the future at http://www.cms.hhs.gov/PCPricer.

PRICER will incorporate the 3-year phase-in period for all current IPFs. New IPFs will be paid completely under the new IPF PPS (i.e., there is no transition for new IPFs).

190.17.1 - Inputs/Outputs to PRICER

(Rev. 1543; Issued: 06-27-08; Effective Date: 07-01-08; Implementation Date: 07-07-08)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator
9	Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.
12	Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)
17	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
18	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)
23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)

38	Special Wage Index
48	New Hospital

Bill Data

National Provider Identifier	**Covered Charges**
OSCAR Number	Discharge Date (or benefits exhaust date if present)
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment
DRG/MS-DRG Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
Per Diem Adjusted Payment
Facility Adjusted Payment
Age Adjusted Payment
Rural Adjusted Payment
Teaching Adjusted Payment
ED Adjusted Payment
ECT Adjusted Payment
Return Code
MSA/CBSA
Wage Index
National Labor Rate

National Non-Labor Rate
Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate
Standardized Factor
Labor Share
Non-Labor Share
COLA
Day of Stay Adjustment
Age Adjustment
Comorbidity Adjustment
DRG Adjustment
Rural Adjustment
ECT Adjustment
Blend Year Calculation Version

Addendum A - Provider Specific File

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

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table>
</td></tr>
</table>

Data Element	File Position	Format	Title	Description
3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting 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).

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. 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 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

Data Element	File Position	Format	Title	Description
				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 **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

Data Element	File Position	Format	Title	Description
				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 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.
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.
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

Data Element	File Position	Format	Title	Description
				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 — Federal % 40 — Facility% 60 3 — Federal % 60 — Facility% 40 4 — Federal % 80 — Facility% 20 5 — Federal % 100 — Facility% 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. 1 — Federal % 25 — Facility% 75 2 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25 4 — Federal % 100 — Facility% 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

Data Element	File Position	Format	Title	Description
				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.
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.
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. 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.
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)

Data Element	File Position	Format	Title	Description
				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 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

Data Element	File Position	Format	Title	Description
				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 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

Data Element	File Position	Format	Title	Description
				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	219-240	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.

Appendix A--Verification of Compliance Using ICD-9-CM and Impairment Group Codes

(Rev. 938, Issued: 05-05-06; Effective/Implementation Date: 08-07-06)

The following ICD-9-CM and impairment group codes from the IRF-PAI database will be used to presumptively verify compliance with the requirements specified above in §140.1.1B. The verification procedure the FI will use is specified above in §140.1.4C "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records." The instructions specified above in §§140.1.4C and 140.1.4D, and in this Appendix, are to be used by the FI when the FI is verifying compliance with the requirements specified above in §140.1.1B. The instructions in §§140.1.4C and 140.1.4D, and this Appendix, are not intended to be used to complete the IRF-PAI. To complete the IRF-PAI, an IRF must use the instructions in the IRF-PAI manual, and any other CMS approved instructions that specifically state how to complete the IRF-PAI. The codes in this Appendix are not intended to be used as part of the instructions when completing the IRF-PAI. This Appendix is only to be used by the FI when it is determining if a facility meets the requirements to be classified as an IRF.

An inpatient, as represented by an IRF-PAI assessment data record, is presumptively determined as being included in the count when the calculation is performed that determines if the compliance thresholds specified in §140.1.1B were met if, except as noted below, the IRF-PAI item number 21 "impairment group" code, or the IRF-PAI item number 22 "etiologic diagnosis" ICD-9-CM code, or the IRF-PAI item number 24a through 24j "comorbid conditions" ICD-9-CM code matches one of the codes listed in the table below. Specifically, in accordance with the verification procedure specified above in §140.1.4C, in order for the IRF-PAI assessment data record, and, thus, the inpatient, to be presumptively counted when calculating if the applicable compliance threshold specified in §140.1.1B was met, the data record must have an impairment group code that matches one of the codes specified in the table column below labeled "REHABILIATION IMPAIRMENT GROUP CODES*", or an etiologic diagnosis or comorbid condition ICD-9-CM code that matches one of the codes specified in the table column below labeled "ICD-9-CM CODES **." However, as illustrated in the table below, if a specific impairment group code is paired with a specific etiologic diagnosis (IRF-PAI item 22) ICD-9-CM code within the same IRF-PAI data record, that pairing will result in that inpatient NOT being presumptively counted in the calculation when the determination is made regarding if the compliance threshold specified in §140.1.1B was met. For example, if an IRF-PAI data record specified both the impairment group code 05.2 (amputation, unilateral upper extremity below the elbow), and an etiologic diagnosis ICD-9-CM code that was either 885.0, or 885.1, or 886.0, or 886.1, then that inpatient is not presumptively counted when the calculation is made that determines if the compliance threshold specified in §140.1.1B was met.

MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
AMPUTATION	05.1 05.2, --BUT NOT	887.0 887.1

	INCLUDING ETIOLOGIC DIAGNOSIS CODES 885.0, 885.1, 886.0, 886.1 05.3 05.4, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 895.0, 895.1, 896.0, 896.1, 896.2, 896.3 05.5 05.6 05.7	887.2 887.3 887.4 887.5 887.6 887.7 897.0 897.1 897.2 897.3 897.4 897.5 897.6 897.7 905.9 997.60 997.61 997.62 997.69 V49.65 V49.66 V49.67 V49.73 V49.74 V49.75 V49.76 V49.77 V52.0 V52.1
BRAIN INJURY	02.1, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 331.0, 331.2, 215.0 02.21 02.22	003.21 006.5 013.00 013.01 013.02 013.03 013.04 013.05 013.06 036.0 036.1 047.0 047.1 047.8 047.9 048 049.0

		049.1 049.8 049.9 052.0 053.0 054.3 055.0 056.01 062.0 062.1 062.2 062.3 062.4 062.5 062.8 062.9 063.0 063.1 063.2 063.8 063.9 064 066.2 066.3 066.4*** 066.41**** 072.1 072.2 090.40 090.41 090.42 091.81 094.1 094.2 094.81 100.81 112.83 114.2 115.01 115.11 115.91 130.0 139.0 191.0 191.1 191.2

		191.3 191.4 191.5 191.6 191.7 191.8 191.9 192.1 194.3 194.4 198.3 225.0 225.2 228.02 237.5 237.6 237.72 310.2 320.0 320.1 320.2 320.3 320.7 320.81 320.82 320.89 320.9 321.0 321.1 321.2 321.3 321.4 321.8 322.0 322.1 322.2 322.9 323.0 323.1 323.2 323.4 323.5 323.6 323.7 323.8 323.9

		324.0 324.9 325 326 344.81 348.0 348.1 348.4 348.5 348.8 349.82 430 432.0 432.1 432.9 800.00 800.01 800.02 800.03 800.04 800.05 800.06 800.09 850.2 850.4 850.5 851.00 851.01 851.02 851.03 851.04 851.05 851.06 851.09 907.0 997.01 013.1x 013.2x 013.3x 013.6x 045.0x 800.1x x=any last digit--see 800.0x 800.2x x=any last digit--see 800.0x 800.3x x=any last digit--see

		800.0x 800.4x x=any last digit--see 800.0x 800.5x x=any last digit--see 800.0x 800.6x x=any last digit--see 800.0x 800.7x x=any last digit--see 800.0x 800.8x x=any last digit--see 800.0x 800.9x x=any last digit--see 800.0x 801.0x x=any last digit--see 800.0x 801.1x x=any last digit--see 800.0x 801.2x x=any last digit--see 800.0x 801.3x x=any last digit--see 800.0x 801.4x x=any last digit--see 800.0x 801.5x x=any last digit--see 800.0x 801.6x x=any last digit--see 800.0x 801.7x x=any last digit--see 800.0x 801.8x x=any last digit--see 800.0x 801.9x x=any last digit--see 800.0x 803.0x x=any last digit--see 800.0x 803.1x x=any last digit--see 800.0x 803.2x x=any last digit--see 800.0x 803.3x x=any last digit--see 800.0x 803.4x x=any last digit--see 800.0x 803.5x x=any last digit--see 800.0x 803.6x x=any last digit--see

		800.0x 803.7x x=any last digit--see 800.0x 803.8x x=any last digit--see 800.0x 803.9x x=any last digit--see 800.0x 804.1x x=any last digit--see 800.0x 804.2x x=any last digit--see 800.0x 804.3x x=any last digit--see 800.0x 804.4x x=any last digit--see 800.0x 804.6x x=any last digit--see 800.0x 804.7x x=any last digit--see 800.0x 804.8x x=any last digit--see 800.0x 804.9x x=any last digit--see 800.0x 851.1x x=5th digit as in 851.0x 851.2x x=5th digit as in 851.0x 851.3x x=5th digit as in 851.0x 851.4x x=5th digit as in 851.0x 851.5x x=5th digit as in 851.0x 851.6x x=5th digit as in 851.0x 851.7x x=5th digit as in 851.0x 851.8x x=5th digit as in 851.0x 852.0x x=5th digit as in 851.0x 852.1x x=5th digit as in 851.0x 852.2x x=5th digit as in 851.0x 852.3x x=5th digit as in

		851.0x 852.4x x=5th digit as in 851.0x 852.5x x=5th digit as in 851.0x 853.0x x=5th digit as in 851.0x 853.1x x=5th digit as in 851.0x 854.0x x=5th digit as in 851.0x 854.1x x=5th digit as in 851.0x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
BURNS	11	906.5 906.7 906.8 941.00 941.02 941.09 941.30 941.32 941.39 946.2 946.3 946.4 946.5 948.1x 948.2x 948.3x 948.4x 948.5x 948.6x 948.7x 948.8x 948.9x 949.3 949.4 949.5 941.4x 941.5x 942.0x 942.3x

		942.4x 942.5x 943.0x 943.2x 943.3x 943.4x 943.5x 944.3x 944.4x 944.5x 945.0x 945.2x 945.3x 945.4x 945.5x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
CONGENITAL DEFORMITIES	12.1, 12.9	253.3 259.4 333.7 334.1 335.10 335.11 343.0 343.1 343.2 343.3 343.4 343.8 343.9 356.0 356.1 356.2 356.3 356.4 356.8 356.9 740.1 740.2 741.00 741.01 741.02 741.03 741.90 741.91

		741.92 741.93 742.0 742.1 742.2 742.3 742.4 742.51 742.53 742.59 754.30 754.31 754.32 754.35 755.20 755.21 755.22 755.23 755.24 755.25 755.26 755.27 755.28 755.30 755.31 755.32 755.33 755.34 755.35 755.36 755.37 755.38 755.4 755.51 755.53 755.61 755.62 755.63 756.4 756.5x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
HIP FRACTURE	8.11, 8.12	733.14 808.0 808.1

		820.00 820.01 820.02 820.03 820.09 820.10 820.11 820.12 820.13 820.19 820.20 820.21 820.22 820.30 820.31 820.32 820.8 820.9
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
BILATERAL KNEE OR BILATERAL HIP JOINT REPLACEMENTS	08.52 08.62 08.72	None
JOINT REPLACEMENTS AND PATIENT AGE 85 OR MORE	08.51 plus age 85 or older 08.61 plus age 85 or older 08.71 plus age 85 or older	None
JOINT REPLACEMENTS AND PATIENT BODY MASS INDEX 50 OR MORE	Codes not applicable. Determination of matching this medical condition based on medical record review.	Codes not applicable. Determination of matching this medical condition based on medical record review.
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
MAJOR MULTIPLE TRAUMA	14.1 14.2 14.3 14.9, --BUT NOT	808.43 808.53 819.0 819.1

	INCLUDING ETIOLOGIC DIAGNOSIS CODES 808.2. 808.3, 808.59, 808.8, 808.9	828.0 828.1
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
NEUROLOGICAL DISORDERS	03.1 03.2 03.5 03.8	053.13 094.0 094.82 138 332.0 332.1 333.0 334.0 335.19 335.20 335.21 335.22 335.23 335.24 335.29 335.8 335.9 340 341.0 341.1 341.8 341.9 344.31 344.32 344.5 344.89 353.0 353.1 353.2 353.3 353.4 353.5 353.8 354.5 356.0 356.1 356.2

		356.3 356.4 356.8 357.0 357.1 357.3 357.4 357.5 357.6 357.7 357.81 357.82 358.00 358.01 358.1 358.2 358.8 359.0 359.1 359.2 359.3 359.4 359.5 359.6 359.81 359.89 710.3 710.4
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
OSTEOARTHRITIS Involving two or more major joints (hips, knees, shoulders, and elbows), not counting any joints with a prosthesis		715.11 715.12 715.15 715.16 715.21 715.22 715.25 715.26 715.31 715.32 715.35 715.36 716.01 716.02 716.05

		716.06 716.11 716.12 716.15 716.16 716.2 716.22 716.25 716.26 716.51 716.52 716.55 716.56
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
RHEUMATOID ARTHRITIS	06.1 06.9, --BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0x, 716.--716.99	099.3 136.1 711.2x 713.0 713.1 713.2 713.3 713.4 713.6 713.7 714.0 714.1 714.2 714.31 714.32 714.81 714.89 714.9 719.3x 720.0 720.81 720.89
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
SPINAL CORD INJURY	04.110, 04.111, 04.112, 04.120, 04.1211, 04.1212, 04.1221, 04.1222, 04.130, --BUT NOT	079.51 170.2 192.2 192.3 225.3

	INCLUDING ETIOLOGIC DIAGNOSIS CODES 723.0, 724.00-724.09 04.210, 04.211, 04.212, 04.220, 04.2211, 04.2212, 04.2221, 04.2222, 04.230 -- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 953.0-953.8	225.4 323.0 324.1 336.0 336.1 336.2 336.3 336.8 336.9 344.00 344.01 344.02 344.03 344.04 344.09 344.1 344.2 344.60 344.61 721.1 721.41 721.42 721.91 722.70 722.71 722.72 722.73 806.00 806.01 806.02 806.03 806.05 806.06 806.07 806.08 806.09 806.10 806.11 806.12 806.13 806.14 806.15 806.16 806.17 806.18 806.19

		806.20 806.21 806.22 806.23 806.24 806.25 806.26 806.27 806.28 806.29 806.30 806.31 806.32 806.33 806.34 806.35 806.36 806.37 806.38 806.39 806.4 806.5 806.60 806.61 806.62 806.69 806.70 806.71 806.72 806.79 839.01 839.02 839.03 839.04 839.05 839.06 839.07 839.08 839.10 839.11 839.12 839.13 839.14 839.15 839.16 839.17

		839.18 839.20 839.21 839.30 839.31 907.2 952.01 952.02 952.03 952.04 952.05 952.06 952.07 952.08 952.09 952.10 952.11 952.13 952.14 952.15 952.16 952.17 952.18 952.19 952.2 952.3 952.4 952.8 952.9 013.4x 013.5x 045.1x 952.1x
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
STROKE	01.1, 01.2, 01.3, 01.4, 01.9	342.00 342.01 342.02 342.10 342.11 342.12 342.80 342.81 342.82 342.90

		342.91 342.92 431 433.01 433.11 433.21 433.31 433.81 433.91 434.01 434.11 434.91 437.2 437.4 437.5 437.6 438.20 438.21 438.22 438.30 438.31 438.32 438.40 438.41 438.42 438.50 438.51 438.52 438.53 997.02
MEDICAL CONDITON	REHABILIATION IMPAIRMENT GROUP CODES*	ICD-9-CM CODES **
SYSTEMIC VASCULIDITIES	06.9-- BUT NOT INCLUDING ETIOLOGIC DIAGNOSIS CODES 710.1, 711.0x, 716.xx	446.0 710.0

* The Rehabilitation Impairment Group codes are from IRF-PAI item number 21. Either the admission or discharge impairment group code may be used.

** The ICD-9-CM codes are from IRF-PAI item number 22 "Etiologic Diagnosis" and item number 24 “Comorbid Conditions."

***Starting on October 1, 2004, this ICD-9-CM code will no longer be one of the ICD-9-CM codes used to determine if an IRF-PAI data record matches one of the medical conditions.

****Starting on October 1, 2004, this ICD-9-CM code will be one of the ICD-9-CM codes used to determine if an IRF-PAI data record matches one of the medical conditions.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1702CP	03/13/2009	April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)	04/06/2009	6416
R1677CP	02/13/2009	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States. Rescinds and fully replaces CR 6217.	03/13/209	6327
R1649CP	12/18/2009	Procedures for Paying Claims Without Passing Through the Integrated Outpatient Code Editor (OCE) or Medicare Code Editor (MCE)	11/25/2008	6252
R1619CP	10/24/2008	Procedures for Paying Claims Without Passing Through the Integrated Outpatient Code Editor (OCE) or Medicare Code Editor (MCE) - Rescinded and replaced by Transmittal 1649	11/25/2008	6252
R1612CP	10/03/2008	Revision of Interim Payment Methodology for Religious Nonmedical Health Care Institution (RNHCI), Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel, Claims Not Billed to the RNHCI Specialty Contractor, and Statutory End of Coverage for RNHCI Items and Services Furnished in the Home	01/05/2009	5383
R1609CP	10/03/2008	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States – Rescinded and replaced by CR 6327, Transmittal 1677	01/05/2009	6217
R1592CP	09/10/2008	Artificial Hearts	12/01/2008	6185
R1585CP	09/05/2008	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2009	10/06/2008	6166
R1583CP	08/29/2008	Artificial Hearts - Replaced by Transmittal 1592	10/06/2008	6185
R1571CP	08/07/2008	Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)	08/15/2008	5849
R1547CP	07/03/2008	Update Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Rate Year 2009	07/07/2008	6114
R1543CP	06/27/2008	Update-Inpatient Psychiatric Facilities	07/07/2008	6077

Rev #	Issue Date	Subject	Impl Date	CR#
		Prospective Payment System (IPF PPS) Rate Year 2009		
R1510CP	05/20/2008	Revision to the Inpatient Prospective Payment System (IPPS) Post Acute Transfer Policy for Discharges/Transfers to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care - Rescinded and Not Replaced	10/06/2008	6012
R1509CP	05/16/2008	Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit	10/06/2008	5860
R1498CP	05/02/2008	Adjusting Inpatient Prospective Payment System (IPPS) Reimbursement for Replaced Devices Offered Without Cost or With a Credit – Replaced by Transmittal 1509	10/06/2008	5860
R1495CP	05/02/2008	Billing Blood and Blood Products	10/06/2008	5867
R1479CP	03/14/2008	April 2008 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer Changes	04/07/2008	5965
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1429CP	02/01/2008	Modification of Payment Window Edits in the Common Working File (CWF) to Look at Line Item Dates of Service (LIDOS) on Outpatient Claims	07/07/2008	5880
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1341CP	09/21/2007	New Web Site for Approved Transplant Centers	10/22/2007	5724
R1311CP	07/20/2007	Capturing Medicare Advantage (MA) Beneficiary Days in the Medicare Supplemental Security Income (SSI) Fraction for Disproportionate Share Hospital (DSH) Data	01/07/2008	5647
R1268CP	06/15/2007	Update – Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2008	07/02/2007	5652
R1231CP	04/27/2007	The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Clarification	12/03/2007	5474

Rev #	Issue Date	Subject	Impl Date	CR#
		of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)		
R1137CP	12/22/2006	Inpatient Rehabilitation Facility (IRF) Teaching Status Adjustment	01/22/2007	5325
R1135CP	12/22/2006	Correction of Instructions for Calculating IRF Compliance Percentage Threshold	03/22/2007	5303
R1105CP	11/09/2006	Swing Bed Hospital Updates	12/11/2006	5114
R1101CP	11/03/2006	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	12/04/2006	5287
R1072CP	10/06/2006	Inpatient Prospective Payment System (IPPS) Outlier Reconciliation Technical Corrections	11/06/2006	5286
R982CP	06/16/2006	New Use of Hospital Issued Notices of Noncoverage (HINNs)	09/18/2006	5070
R981CP	06/15/2006	Update-Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007	07/03/2006	5202
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R966CP	05/26/2006	Intestinal and Multi-Visceral Transplantation	06/26/2006	5090
R957CP	05/19/2006	Pancreas Transplants Alone (PA)	07/03/2006	5093
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R938CP	05/05/2006	The Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	08/07/2006	5016
R903CP	04/14/2006	Payment for Blood Clotting Factors Administered to Hemophilia Inpatients	07/14/2006	4229
R851CP	02/10/2006	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions Specialty Contractor Regarding Claims for Beneficiaries with RNCHI Elections	05/11/2006	4218
R843CP	02/09/2006	Inpatient Admission Followed by Discharge or Death Prior to Room Assignment	07/03/2006	4202
R836CP	02/03/2006	Inpatient Admission Followed by Discharge or Death Prior to Room Assignment	07/03/2006	4202
R817CP	01/20/2006	Update to the Inpatient Provider specific File and the Outpatient Provider Specific File to Retain Provider Information	04/03/2006	4279
R803CP	01/03/2006	Administration of Drugs and Biologicals in a	04/03/2006	4234

Rev #	Issue Date	Subject	Impl Date	CR#
		Method II Critical Access Hospital (CAH)-Rescinds and Replaces CR 3911		
R776CP	12/06/2005	Stem Cell Transplantation	01/03/2006	4173
R771CP	12/02/2005	Revisions to Pub. 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier	01/03/2006	4181
R768CP	12/02/2005	Lung Volume Reduction Surgery	03/02/2006	4149
R766CP	12/02/2005	Stem Cell Transplantation	01/03/2006	4173
R714CP	10/21/2005	Payment Window Edit Corrections within the Common Working File (CWF)	04/03/2006	4089
R707CP	10/12/2005	IPPS Outlier Reconciliation	11/07/2005	3966
R703CP	10/07/2005	IPPS Outlier Reconciliation	11/07/2005	3966
R698CP	10/07/2005	The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2006 for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	11/07/2005	4065
R693CP	09/30/2005	Updates to the IRF and SNF Provider Specific File and Changes in Inpatient Rehabilitation Facility Prospective Payment System For FY 2006	10/31/2005	4099
R668CP	09/02/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
R654CP	08/19/2005	Services Not Provided Within United States	11/17/2005	3781
R646CP	08/12/2005	Update to the Inpatient Provider Specific File (PSF) and the Outpatient PSF to Retain Provider Information	01/03/2006	3940
R632CP	07/29/2005	Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations	01/03/2006	3949
R622CP	07/29/2005	Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims during an Inpatient Stay	01/03/2006	3933
R619CP	07/29/2005	Late IRF-PAI Data Submission Penalty Protocol Within the Inpatient Rehabilitation Facility Prospective Payment System	01/03/2006	3885
R594CP	06/24/2005	Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare	07/01/2005	3903
R577CP	06/03/2005	Preliminary Instructions: Expedited	07/01/2005	3903

Rev #	Issue Date	Subject	Impl Date	CR#
		Determinations/Reviews for Original Medicare		
R530CP	04/22/2005	Billing Requirements for Physician Services Rendered in Method II Critical Access Hospitals (CAHs)	07/05/2005	3800
R526CP	04/15/2005	Updated Requirements for Autologous Stem Cell Transplantation (AuSCT)	05/16/2005	3797
R478CP	02/18/2005	Clarification of the Verification Process to be Used to Determine if the Inpatient Rehabilitation Facility Meets The IRF Classification Criteria	03/21/2005	3704
R465CP	02/04/2005	Billing Requirements for Physician Services in Method II Critical Access Hospitals (CAHs)	07/05/2005	3559
R392CP	12/10/2004	The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Year 2003 for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)	01/10/2005	3567
R384CP	12/01/2004	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)	04/04/2005	3541
R383CP	11/26/2004	Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Replaced by Transmittal 384.	04/04/2005	3541
R379CP	11/26/2004	Low Osmolar Contrast Material/Laboratory Tests/Payment for Inpatient Services Furnished by a Critical Access Hospital (CAH)	04/04/2005	3439
R357CP	11/05/2004	Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706	04/04/2005	3529
R347CP	10/29/2004	Inpatient Rehabilitation Facility (IRF) Classification Requirements	11/29/2004	3503
R291CP	08/27/2004	Use of Transmission Date in the Service Date/Assessment Date Field for Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Claims	01/03/2005	3433
R285CP	08/27/2004	Addition of Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists as Emergency On-Call Providers for Critical Access Hospitals (CAHs)	01/03/2005	3228

Rev #	Issue Date	Subject	Impl Date	CR#
R276CP	08/13/2004	Further Information Related to CR 3175, Distinct Part Units of Critical Access Hospitals (CAHs)	01/03/2005	3399
R267CP	07/30/2004	Crossover Patients in New Long Term Care Hospitals (LTCH)	01/03/2005	3391
R266CP	07/30/2004	Revision of Common Working File (CWF) Editing for Same-Day, Same- Provider Acute Care Readmissions	01/03/2005	3389
R263CP	07/30/2004	Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer for FY 2005	10/04/2004	3378
R231CP	07/23/2004	Indian Health Service or Tribal Critical Access Hospitals Billing for Professional Services	01/03/2005	3235
R221CP	06/25/2004	Medicare IRF Classification Requirements	07/01/2004	3334
R208CP	06/18/2004	Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update	07/06/2004	3335
R161CP	04/30/2004	Informing Beneficiaries about which local Medical Review Policy (LMRP) and /or Local Coverage Determination (LCD) and o/or National Coverage Determination (NCD) is associated with their claim denial - rescinded and replaced with Pub. 100-08, Transmittal 75.	10/04/2004	3089
R156CP	04/30/2004	Clarification of payments and billing procedures for hospitals subject to the Maryland waiver	10/04/2004	3200
R152CP	04/30/2004	Inclusion of Core-Based Statistical Area (CBSA) Data Elements to the Provider Specific Files	10/04/2004	3272
R144CP	04/23/2004	Distinct Part Units for Critical Access Hospitals	10/04/2004	3175
R087CP	02/06/2004	Expansion of Transfer Policy Under Inpatient Payment Prospective System	07/06/2004	2934
R077CP	02/06/2004	Change in Methodology for Determining Payment for Outliers	03/08/2004	2998
R073CP	01/23/2004	MCE and IPPS Transfers Between Hospitals	N/A	2716 & 2891

Rev #	Issue Date	Subject	Impl Date	CR#
R070CP	01/23/2004	Hospital Operating Payments Under PPS	02/23/2004	3038
R068CP	01/16/2004	New Requirements for Critical Access Hospitals. These changes have been established with the "Medicare Prescription Drug, Improvement, and Modernization Act" (MPDIMA) of 2003, Pub.L. 108-173	04/05/2004	3052
R039CP	12/08/2003	Low-Income Provides Adjustment: The Supplemental Security Income Medicare Beneficiary Data for Fiscal Year 2002 for IRFs Paid Under the PPS	01/05/2004	2978
R026CP	11/04/2003	Lung Volume Reduction Surgery	01/05/2004	2688
R010CP	10/17/2003	Heart Transplants	10/01/2003	2958
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

Back to top of Chapter