CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 263 **Date: JULY 30, 2004**

CHANGE REQUEST 3378

SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2005

I. SUMMARY OF CHANGES: This CR indicates the changes that will be required as part of the annual IRF PPS update for FY 2005. Annual updates to the IRF PPS rates are required by §1886(j) of the Social Security Act. Under the existing IRF PPS outlier methodology, the CCR from an IRF's latest settled cost report is used in determining whether a case qualifies for payment as an outlier and the amount of any such payment. Based on the notice published in the **Federal Register** on July 30, 2004, this CR provides instructions for applying CCRs for IRFs, including: the use of an alternative CCR when directed by CMS or at the request of the facility and the use of a CCR based on the tentative settlement of the cost report for discharges on or after October 1, 2004; use of the national averages; the criteria for identifying hospitals to be subject to reconciliation; and notification to hospitals about those updates.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/140.2.6/ Outlier Payments: Cost-to-Charge Ratios

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

***Medicare contractors only**

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 263	Date: July 30, 2004	Change Request 3378

SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2005

I. GENERAL INFORMATION

This attachment is to inform you of the changes that will be required as part of the annual IRF PPS update for FY 2005.

A. Background: On August 7, 2001, we published in the **Federal Register,** a final rule that established the PPS for IRFs, as authorized under §1886(j) of the Social Security Act (the Act). In that final rule, we set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by §1886(j)(3)(C) of the Act. Regulations at 42 CFR §412.624(e)(4) describe the criteria and procedures for determining whether an inpatient rehabilitation facility subject to the inpatient rehabilitation facility prospective payment system (IRF PPS) qualifies for an additional payment for extraordinarily costly cases, known as high-cost outliers. A final rule, published on August 1, 2003 (68 FR 45674) revised the regulations at §412.624(e)(4) for facilities subject to the IRF PPS. This Change Request (CR) provides instructions for implementing those revisions to the outlier policy for the IRF PPS.

B. Policy: On August 1, 2003, we published a final rule in the **Federal Register** (68 FR 45674) that sets forth the prospective payment rates applicable for IRFs for FY 2004. On July 30, 2004, we published a notice that sets forth the prospective payment rates applicable to IRFs for FY2005. A new IRF PRICER software package will be released prior to October 1, 2004 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2004 through September 30, 2005. The new revised Pricer program must be installed timely to ensure accurate payments for the IRF PPS claims with discharges on or after October 1, 2004 through September 30, 2005. Under the existing IRF PPS outlier methodology, the CCR from an IRF's latest settled cost report is used in determining whether a case qualifies for payment as an outlier and the amount of any such payment. Based on the final rule published in the **Federal Register** on August 1, 2003, this CR provides instructions for applying CCRs for IRFs, including: the use of an alternative CCR when directed by CMS or at the request of the facility and the use of a CCR based on the tentative settlement of the cost report for discharges on or after October 1, 2003; use of the national averages; the criteria for identifying hospitals to be subject to reconciliation; and notification to hospitals about those updates.

C. Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within one week of the release of this instruction. In addition, the entire instruction shall be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3378.1	FISS shall install and pay IRF claims with the IRF Pricer for discharges on or after October 1, 2004, which includes all CMS updates to FY 2005 changes.	FISS
3378.2	FIs shall update IRF provider specific files.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN ONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3378.1	The new IRF Pricer module will not contain any new calculation logic, but will simply apply the existing calculations to the updated rates.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3378.1	The input and output records of the IRF Pricer module will not be changed.

C. Interfaces: IRF Pricer and IRF Provider Specific Files

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Sarah Shirey at 410-786-0187 for claims related questions or August Nemec at 410-786-0612 for policy questions. **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions shall be implemented within your current operating budget.**

140.2.6 – Outlier Payments: Cost-to-Charge Ratios

(Rev, 263, Issued 07-30-04, Effective: 10-01-04, Implementation: 10-04-04

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 cost-to-charge ratio 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 cost-to-charge ratio 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). We 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 cost-to-charge ratios 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 cost-to-charge ratios are 0.636 for rural IRFs and 0.531 for urban IRFs.

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 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 IRF PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio 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 Cost-To-Charge Ratios 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 cost-to-charge ratio.

B - Calculating Medicare Cost-To-Charge Ratios 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). All references to Worksheets and specific line numbers should correspond with the subprovider identified as the IRF unit, i.e., the letter "T" is in the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

C - Calculating Medicare Cost-To-Charge Ratios 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 cost-to-charge-ratio based on the facility location of either urban or rural will be used. Specifically, for FY 2005, CMS has estimated a national cost-to-charge ratio 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 cost-to-charge ratio 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% 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 cots 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

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.