CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 152 **Date: APRIL 30, 2004**

CHANGE REQUEST 3272

I. SUMMARY OF CHANGES: Core-based statistical area (CBSA) data elements are being added to the provider specific files and instructions on how to submit these files are also being updated.

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) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/20.2.3.1/Provider Specific File
R	3/Addendum A/Provider Specific File
R	4/50.1/Oupatient Provider Specific File

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 152	Date: April 30, 2004	Change Request 3272

SUBJECT: Inclusion of Core-Based Statistical Area (CBSA) Data Elements to the Provider Specific Files

I. GENERAL INFORMATION

A. Background:

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."

B. Policy

In the December 27, 2000, **Federal Register** (65 FR 82228 - 82238), OMB announced its new standards. According to that notice, OMB defines Core-Based Statistical Areas (CBSAs), beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. The standards designate and define two categories of CBSAs: Metropolitan Statistical Areas and Micropolitan Statistical Areas." (65 FR 82235)

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3272.1	Fiscal intermediaries and Shared System Maintainers shall update their Provider Specific File records to include all fields as stated in the Medicare Claims Processing Manual, Chapter 3, Addendum A.	FIs and SSMs
3272.1.1	Fiscal intermediaries shall submit their Provider Specific File records in accordance with the Medicare Claims Processing Manual, Chapter 3, section 20.2.3.1.	FIs
3272.1.2	Fiscal intermediaries shall submit their updated Provider Specific File quarterly to CMS Central	FIs

	Office starting mm/dd/yyyy.	
3272.2	Fiscal intermediaries and Shared System Maintainers shall update their Outpatient Provider Specific File records to include all fields as stated in the Medicare Claims Processing Manual, Chapter 4, section 50.1.	FIs and SSMs
3272.2.2	Fiscal intermediaries shall submit their Outpatient Provider Specific File records in accordance with the Medicare Claims Processing Manual, Chapter 4, section 50.1.	FIs
3272.2.2	Fiscal intermediaries shall submit their updated Outpatient Provider Specific File quarterly to CMS Central Office starting mm/dd/yyyy.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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):** Joe Bryson At jbryson2@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

20.2.3.1 – Provider Specific File

(Rev. 152, 04-30-04)

A3-3850 Transmittal 1863A3

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.

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), SNF's, 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.

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

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

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

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.

D - Skilled Nursing Facility (SNF)

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. 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.

E - Home Health Agency (HHA)

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)

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 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type

G – Long Term Care Hospital (LTCH)

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 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

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

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.

Addendum A - Provider Specific File

(Rev. 152, 04-30-04)

A-03-058 (for CCR development)

	File Position	Format	Title	Description
1	1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character Identifier (NPI) Provider number.
2	9-10	X(2)	NPI Filler	Blank.
3	11-16	X(6)	Provider Oscar No.	Alpha-numeric 6 character provider number. Cross check to Item 10, provider type. Positions 3 and 4 of:

Provider #	Type (see field 10)
00-08	Blanks, 00, 07-11, 13-17, 21-22
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Codes for special units S, T, U, V, W, U and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).

	File Position	Format	Title	Description
4	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. Month 01-12, day 01-31, year greater than 82 but not greater than current year.
5	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD Day: 01-31, Month: 01-12 Year: Greater than 81, but not greater than current year. 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 (Field #4 above).
6	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
7	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.
8	49	X	Waiver Indicator	Provider waived from PPS? Must be Y

	File Position	Format	Title	Description
				(yes) or N (no). Y = means waived (Provider is not under PPS). N = means not waived (Provider is under PPS).
9	50-54	9(5)	*I*ntermediary Number	Assigned intermediary number.
10	55-56	X(2)	Provider Type	This identifies providers that require special handling. The FI enters the appropriate code: Must be blank or 00, 02-08, 13-18, 21-23, or 32-38. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (During cost reporting periods that began on or after 4-1-90.) 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after 4-1-90. Invalid 10/1/94 through 90-30-97. See §20.6B.) 16 Rebased Sole Community Hospital 17 Rebased Sole Community Hospital/Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital (EACH) 22 Essential Access Community Hospital/Referral Center

	File Position	Format	Title	Description
				23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project - Phase II (SNF only) 33 Nursing Home Case Mix Quality Demonstration Project - Phase III Step 1 (SNF only) 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) - For Non demo PPS SNF's - eff. for cost reporting periods beginning on or after 7/1/98.
11	57	9	Current Census Division	Must be numeric (1-9). The Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, FIs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific
				NOTE: When a facility is reclassified for purposes of the standard amount, the FI changes the census division to reflect the new standardized amount location.
12	58	X	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.

	File Position	Format	Title	Description
13	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.
14	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.
15	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
16	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.
17	73	X	Change Code for 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

	File Position	Format	Title	Description
				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.
18	74	X	Temporary Relief Indicator	Enter a 'Y' if this provider qualifies for a payment update under the temporary relief provision, *otherwise leave blank*.
19	75	X	Federal PPS Blend Indicator	HHA: Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. LTCH: 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
20	76-89	X(5)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost

	File Position	Format	Title	Description
			Per Discharge/PPS Facility Specific Rate	per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91	9V9(3)	Cost of Living Adjustment *(COLA)*	*Enter the COLA*. All hospitals except Alaska and Hawaii use 1.000.\
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 nonteaching hospitals.
24	97-101	9(5)	Bed Size	*Enter* the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by

	File Position	Format	Title	Description
				the 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

	File Position	Format	Title	Description
				operating DSH adjustments.
29	119	X	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*	*Code 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*	*Code indicats hospital meets criteria to receive higher payment per MMA quality standards.* *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*	*Enter the appropriate code for the CBSA,*

	File Position	Format	Title	Description
			Location CBSA	*00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.*
37	*150-154*	*X(5)*	*Standardized Amount Location CBSA*	*Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank*
38	*155-160*	*9(2)V9(4)*	*Special Wage Index*	*Enter the special wage index that certain providers may be assigned. Enter zeroes unless field 33 = "1" or "2"*
39	161-166	9(4)V99	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Ust 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)V99	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)V99	Pass Through Amount for Organ	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, and

	File Position	Format	Title	Description
			Acquisition	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)V99	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero fill if this does not apply.
43	185	X	Capital PPS Payment Code	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 Must be present unless a "Y" is entered in location 49 (position 207), or 08 is entered in location 55-56 or a termination date is present in location 41-48.
44	186-191	9(4)V99	Hospital Specific Capital Rate	*Enter the* hospital's allowable adjusted base year inpatient capital costs per discharge. *This field is not used as of 10/1/02*.

	File Position	Format	Title	Description
45	192-197	9(4)V99	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	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the FI is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The FI uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X	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	*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

	File Position	Format	Title	Description
				fiscal year by the hospital's total inpatient days. See §20.4.1 above.) Zero fill for a non-teaching hospital.
50	213-218	9(4)V99	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.

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, reconciliations 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

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.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

50.1 - Outpatient Provider Specific File

(Rev. 152, 04-30-04)

The outpatient provider (OPROV) specific file contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and format are shown below. FIs must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. *An update* is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.
FIs must also furnish CMS a quarterly file in the same format. *Note: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.*

File Position	Format	Title	Description
1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character provider number
9-10	X(2)	NPI Filler	Blank
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CO
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X	Waiver Indicator	"N" means not waived (under OPPS) and "Y" means waived (not under OPPS).
50-54	9(5)	Intermediary Number	Intermediary #

55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter the appropriate code (must be blank or 00, 02-08, 13-18, 21-23, or 32-38): 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998
57	*X(1)*	*Special Locality Indicator*	*Indicates the type of special locality provision that applies.*
58	X	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified.

67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio.
71-75	9(5)	Bed Size	Indicate the number of adult hospital beds and pediatric beds available.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data.
80-*84*	*X(5)*	*Actual Geographic Location CBSA*	*00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.*
85-89	*X(5)*	*Wage Index Location CBSA*	*Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.*
90-95	*9(2) V9(4)*	*Special Wage Index*	*Enter the special wage index that certain providers may be assigned. Enter zeroes unless field 33 = "1" or "2"*
96	*X(1)*	*Special Payment Indicator*	*Code 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*
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

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

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

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