CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 77 **Date: FEBRUARY 6, 2004**

CHANGE REQUEST 2998

I. SUMMARY OF CHANGES: 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.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2003
***IMPLEMENTATION DATE: March 8, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(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: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Business Requirements

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I. GENERAL INFORMATION

A. Background: 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: 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: Intermediaries shall inform affected provider communities by posting relevant portions of this CR on their Web sites within 2 weeks of the issuance date of this CR. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about "Change in Methodology for Determining Payment for Outliers Under the Inpatient Rehabilitation Facility Prospective Payment Systems" is available on your Web site.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2998.1	Fiscal intermediaries (FIs) shall update their IRF PPS provider specific files by October 1, 2003.	FIs
2998.2	FIs shall notify an IRF whenever they make a change to its CCR.	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: Provider Specific File

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, 2003 **Implementation Date: March 8, 2004** **Pre-Implementation Contact(s): Bob Kuhl** **Post-Implementation Contact(s): Regional Office**	**These instructions should be implemented within your current operating budget.**

140.2.6 - Outlier Payments: Cost-to-Charge Ratios

(Rev. 77, 02-06-04)

This section describes the appropriate data sources for computing an overall Medicare facility-specific cost-to-charge ratio 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 or 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 when the IRF has a CCR that falls above three standard deviations from the national mean (upper threshold). The upper threshold is 1.461. We will not use a lower threshold and an IRF will receive their actual CCR, no matter how low their ratio falls.

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 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.

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, CMS has estimated a national cost-to-charge ratio of *0.597* for rural IRFs and *0.554* 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.