Medicare
Provider Reimbursement Manual
Part 1 - Chapter 28
Prospective Payments

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

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2801 – 2802 (Cont.)	28-5 – 28-6 (2 pp.)	28-5 – 28-6 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: October 16, 2003

Section 2801, Hospital Prospective Payment System Base Period and Target Amount, is revised to include language for the health care industry that permits the use of Diagnosis Related Groups (DRGs) other than Medicare DRGs on HIPAA standard electronic transactions with health plans other than Medicare.

2801. HOSPITAL PROSPECTIVE PAYMENT SYSTEM BASE PERIOD AND TARGET AMOUNT (Cross refer to §§2406, 2407 and A 2406)

Special Note Concerning Diagnosis Related Groups (DRGs) as Related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice (which is outside the context of the instructions in Chapter 28) applies to the use of DRGs on HIPAA standard electronic transactions. The X12 Implementation Guides state that the Source of DRG codes is Source 229 (HCFA), HIM-15. (For that reason, this Notice has been included in Chapter 28, which addresses DRGs.) The Implementation Guides are incorrect because they imply, by using a Medicare publication as the DRG code source, that only Medicare DRGs may be used on HIPAA standard electronic transactions.

DRG codes other than Medicare DRG codes may be used on HIPAA standard electronic transactions with health plans other than Medicare. Providers, if required to report DRGs on HIPAA standard electronic claims, are to report the DRG codes used by the health plan being billed. Health plans other than Medicare, in creating HIPAA-compliant payment and remittance advice transactions, may use DRGs other than Medicare DRGs. Health care providers should contact the health plans they are billing in order to obtain the DRG codes to be reported.

The Centers for Medicare & Medicaid Services (CMS) plans to compile a list of sources of DRG codes used in the health care industry, which would be a helpful resource. The list, once compiled, will be posted to the CMS Web site.

The Social Security Amendments of 1983(PL 98-21) provide that effective with cost reporting periods beginning on or after October 1, 1983, Medicare's payment for Part A hospital inpatient operating costs will be made prospectively on a per discharge basis. Part A inpatient hospital operating costs include those costs (including malpractice insurance costs) for general routine service, ancillary service, and intensive care-type unit services with respect to inpatient hospital services but exclude capital-related and direct medical education costs. Inpatient hospital services are defined as all services provided regardless of source, except for physician services. Payment for other inpatient hospital costs (i.e., capital-related costs, medical education costs,) and for Part B inpatient ancillary and outpatient services, will continue to be paid retrospectively on a reasonable cost basis.

2802. PAYMENT RATES DURING TRANSITION

Under the prospective payment system, each Medicare discharge will be classified into diagnosis related groups (DRGs) and a specific payment rate will be established for each DRG by geographic area. During a 3-year transition period, the prospective payment rate for a given Medicare discharge will be based on a combination of 1) a rate per discharge (subsequently referred to as "target amount per discharge"), based on the hospital's historical cost experience in a base period adjusted by the hospital's case-mix index, and 2) the DRG specific payment rate. After the transition period, the payment will be based only on the DRG-specific payment rate (see F. below). An additional payment will be made to the prospective payment amount for hospitals that have an approved graduate medical education program as defined in 42 CFR 405.421. In order for intermediaries to make the payment, hospitals will need to submit the number of interns and residents it employs along with base period cost adjustment data (see G. below).

Target Rate

The target rate that will comprise one portion of the prospective payment during the transition period is determined on a prospective basis without reference to the hospital's costs in the current year. It is developed by increasing the hospital's base period allowable inpatient operating costs per discharge, as adjusted by the hospital's case-mix index, by an inflation factor during the intervening years. Intermediaries will determine the base period costs and target amount per discharge and notify the hospital of the determination as provided below.

A. Base Period Cost Report--The base period cost is developed from cost data for the next to the last 12 month (or longer) cost reporting period preceding the first cost reporting period subject to the prospective payment system. Thus, the base period under the prospective payment system is generally the same as the base period under §101 of TEFRA and is the 12-month cost reporting period ending on or after 9/30/82 and before 9/30/83.

Example:

1st Fiscal Year Subject to Prospective Reimbursement	Base Period
10/1/83 - 9/30/84	10/1/81 - 9/30/82
1/1/84 - 12/31/84	1/1/82 - 12/31/82
7/1/84 - 6/30/85	7/1/82 - 6/30/83

NOTE: Generally the same base period is used for the prospective payment system and for §101 TEFRA rate of increase ceiling purposes. Also many of the same adjustments will apply for both. Thus collection of data and activities to adjust the base period should be coordinated to the extent possible. Adjustment of the base period for both prospective payments and §101 of TEFRA can then be accomplished in the same format. (See Exhibits A, B and C.) HOWEVER, INTERMEDIARIES WILL PROCEED WITH COMPLETING THE PROSPECTIVE PAYMENT SYSTEM BASE PERIOD AND TARGET AMOUNT CALCULATIONS AS REQUIRED BY THESE INSTRUCTIONS EVEN IF THERE IS ANY DELAY WITH OR DISPUTE BETWEEN THE INTERMEDIARY AND PROVIDER OVER DEVELOPMENT OR COMPUTATION OF TEFRA ADJUSTMENTS OR BASE PERIOD COSTS.