CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2111	**Date: December 3, 2010**
	Change Request 7192

SUBJECT: Outlier Reconciliation and other Outlier Manual Updates for the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Rehabilitation Facility (IRF) PPS, Inpatient Psychiatric Facility (IPF) PPS and Long Term Care Hospital (LTCH) PPS

I. SUMMARY OF CHANGES: The purpose of this transmittal is to instruct FISS to update the Lump Sum Utility (created in the confidential CR 6267) for the IPPS, LTCH PPS, IRF PPS, IPF PPS and OPPS with additional output fields and to use the appropriate versions of Pricer. The updated utility will then be used by Medicare contractors to re-price outlier claims offline without affecting Co-Pays, Lifetime Reserve Days or the Medicare Summary Notice (MSN). Within this transmittal, we are also establishing criteria for outlier reconciliation for the IPF PPS. Additionally, we are manualizing the instructions from transmittal A-03-058 for the LTCH PPS. We also provide guidance to Medicare contractors how to use the Lump Sum Utility for each of the PPSs mentioned above. Finally, we are also issuing formal manual instructions on cost-to charge ratios, alternative cost-to-charge ratios, statewide and national average CCRs for the respective PPS and mergers and acquisitions that mirror the instructions for the IPPS.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.1.2/Outliers
R	3/20.1.2.1/Cost to Charge Ratios
R	3/20.1.2.2/Statewide Average Cost to Charge Ratios
R	3/20.1.2.3/Threshold and Marginal Cost
R	3/20.1.2.4/Transfers
R	3/20.1.2.5/Reconciliation
R	3/20.1.2.6/Time Value of Money
R	3/20.1.2.7/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/140.2.4.4/Outliers
R	3/140.2.6/Cost-to-Charge Ratios
N	3/140.2.7/Use of a National Average Cost-to-Charge Ratio
N	3/140.2.8/Reconciling Outlier Payments for IRFs
N	3/140.2.9/Time Value of Money
N	3/140.2.10/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs
R	3/150.24/Determining the Cost-to-Charge Ratio
N	3/150.25/Statewide Average Cost-to-Charge Ratios
N	3/150.26/Reconciliation
N	3/150.27/Time Value of Money
N	3/150.28/Procedure for Medicare contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/190.7.2/Outlier Policy
R	3/190.7.2.2/Determining the Cost-to-Charge Ratio
N	3/190.7.2.3/Outlier Reconciliation
N	3/190.7.2.4/Time Value of Money
N	3/190.7.2.5/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	4/10.7.2.1/Identifying Hospitals and CMHCs Subject to Outlier Reconciliation
R	4/10.7.2.3/Time Value of Money
R	4/10.7.2.4/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	4/10.11.11/Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2111	Date: December 3, 2010	Change Request: 7192

SUBJECT: Outlier Reconciliation and other Outlier Manual Updates for the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Rehabilitation Facility (IRF) PPS, Inpatient Psychiatric Facility (IPF) PPS and Long Term Care Hospital (LTCH) PPS

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background:

The IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS all have similar regulations concerning outliers, cost-to-charge ratios and outlier reconciliation which are effective on different dates and discussed in full detail in the policy section below. Prior to the issuance of this transmittal, the IPPS and LTCH PPS issued transmittal A-03-058 (change request 2785) on July 3, 2003 which provided instructions to Medicare contractors on the implementation of the new outlier regulations (due to outlier turbocharging) at § 412.84 for the IPPS and §§ 412.525 and 412.529 for the LTCH PPS. Transmittal A-03-058 established criteria to determine which hospitals under the IPPS and LTCH PPS are eligible for outlier reconciliation. Transmittal A-03-058 also instructed Medicare contractors to update the PSF on an ongoing basis with the final settled or tentatively final settled CCR (whichever is from the latest period) and provided instructions on applying an alternative CCR to the tentatively settled CCR or final settled CCR (whichever is from the later period). We also provided instructions when to apply the statewide average CCRs. We note that transmittal A-03-058 can be found in the appendix of chapter 3 of the claims processing manual.

On October 12, 2005 we issued transmittal 707 (change request 3966) which revised section 20.1.2 of Chapter 3 of the Medicare Claims Processing Manual and manualized the instructions from transmittal A-03-058 for the IPPS. Transmittal 707 also provided further instruction on the policies of IPPS outlier reconciliation and how to apply the time value of money to the reconciled outlier dollar amount. Additionally, transmittal 707 instructed Medicare contractors how to calculate IPPS operating and capital cost-to-charge ratios, which cost-to-charge ratio to apply in instances of hospital mergers and what to do when errors occur with cost-to-charge ratios and outlier payments. Similar to the IPPS, the IRF PPS issued transmittal 263 in July 30, 2004 which mirrors some of the IPPS instructions in transmittal 707. Additionally, the OPPS issued Transmittal 1657 on December 31, 2008, which also mirrors the IPPS instructions in transmittal 707.

Since the issuance of the transmittals and change requests mentioned above, due to system limitations, we were unable to reconcile any hospital outlier claims paid under the IPPS, IRF PPS, LTCH PPS and OPPS. We also did not provide a process for Medicare contractors on how to reconcile outlier claims for those providers already flagged for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS and OPPS or that could potentially be flagged for outlier reconciliation.

The purpose of this transmittal is to instruct FISS to update the Lump Sum Utility (created in the confidential CR 6267) for the IPPS, LTCH PPS, IRF PPS, IPF PPS and OPPS with additional output fields and to use the appropriate versions of Pricer. The updated utility will then be used by Medicare contractors to re-price outlier claims offline without affecting Co-Pays, Lifetime Reserve Days or the Medicare Summary Notice (MSN). Within this transmittal, we are also establishing criteria for outlier reconciliation for the IPF PPS. Additionally, we are manualizing the instructions from transmittal A-03-058 for the LTCH PPS. We also provide guidance to

Medicare contractors how to use the Lump Sum Utility for each of the PPSs mentioned above. Finally, we are also issuing formal manual instructions on cost-to charge ratios, alternative cost-to-charge ratios, statewide and national average CCRs for the respective PPS and mergers and acquisitions that mirror the instructions for the IPPS from transmittal 707 for the LTCH PPS and IPF PPS.

We note that we have combined some of the business requirements that are repetitive for the various PPSs. However, the actual instructions for each PPS are in the appropriate section of the Medicare Claims Processing Manual (Pub. 100-04) which can be found in the following sections:

IPPS- Chapter 3, Section 20.1.2 - 20.1.2.7
IRF PPS- Chapter 3, Section 140.2.4.4 and 140.2.6 - 140.2.10
LTCH PPS- Chapter 3, Section 150.24 - 150.28
IPF PPS- Chapter 3, Section 190.7.2 – 190.7.2.5
OPPS- Chapter 4, Section 10.7.2 – 10.7.2.1 and 10.7.2.3 – 10.7.2.4

B. Policy:

The outlier payment policy, application of alternative CCRs and outlier reconciliation for the IPPS, LTCH PPS, IRF PPS, IPF PPS and OPPS are found in different places within Part 42 of the Code of Federal Regulations. Below we explain the policy for each PPS. As discussed above, some of the policies for the IPPS and OPPS have already been manualized. Below we list the applicable regulations that we are manualizing in this transmittal for each PPS.

IPPS

For the Inpatient Prospective Payment System (IPPS), 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.

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 cost-to-charge ratio 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.

In addition, under 42 CFR § 412.84(i)(4), effective for discharges occurring on or after August 8, 2003, at the time of reconciliation under paragraph (h)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

LTCH PPS

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, when the LTCH PPS was implemented (for cost reporting periods beginning on or after October 1, 2002), we established an adjustment for additional payments for outlier cases that have extraordinarily high-costs relative to the costs of most discharges at §412.525(a). Providing additional

payments for high cost outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient level and hospital level. Specifically, under §412.525(a), we make high cost outlier payments to LTCHs for any discharge if the estimated cost of the case exceeds the adjusted LTCH PPS payment for the case plus a fixed-loss amount. Under the LTCH PPS high-cost outlier policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold. We calculate the estimated cost of a LTCH case by multiplying the Medicare allowable covered charge by the overall hospital cost-to-charge ratio (CCR). In accordance with §412.525(a)(3), we pay outlier cases additional payment 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the case and the fixed-loss amount).

Additionally, when we implemented the LTCH PPS, we established a special payment policy for short-stay outlier cases. LTCH PPS cases with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for each LTC-DRG are short stay outliers. Generally, LTCHs are defined by statute as having an average Medicare length of stay of greater than 25 days. Under the current short-stay outlier policy at §412.529(c), the adjusted payment for the case is the least of several payment options, one of which is 100 percent of the estimated cost of the case (prior to July 1, 2006, the short-stay outlier payment formula included 120 percent of the estimated cost of the case as one of the payment options). Consistent with the LTCH PPS high-cost outlier policy, under the short-stay outlier policy at §412.529, we calculate the estimated cost of a case by multiplying the Medicare allowable covered charges by the overall hospital cost-to-charge ratio.

The regulations for the LTCH PPS are similar to the IPPS outlier regulations at in §412.84(i). Specifically, in the June 9, 2003 IPPS outlier payment final rule, beginning October 1, 2003 we implemented new regulations initially at §412.525(a)(4)(iii) (which is now codified in the regulations at §412.525(a)(4)(iv)(B) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(iii) (which is now codified in the regulations at §412.529(f)(3) and §412.529(f)(4)(ii)) that allows FIs or A/B MACs to use the best available data (that is, data from the most recent tentative settled cost report, whichever is from the later cost reporting period) when determining the CCR for each hospital (similar to the IPPS policy at §412.84(i)(2)).

In the June 9, 2003 final rule, effective August 8, 2003, we also implemented new regulations initially at §412.525(a)(4)(ii) (which is now codified in the regulations at §412.525(a)(4)(iv)(A) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(ii) (which is now codified in the regulations in §412.529(f)(2) and §412.529(f)(4)(i)) to allow a LTCH to contact its FI or A/B MAC to request that its CCR, otherwise applicable, be changed if the LTCH presents substantial evidence that the ratios are inaccurate (similar to the IPPS policy set forth under 412.84(i)(1). Any such requests must be approved by the CMS RO with jurisdiction over that FI or A/B MAC.

Additionally, in the June 9, 2003 final rule, effective August 8, 2003, we also implemented regulations initially at §412.525(a)(4)(ii) (which is now codified in the regulations at §412.525(a)(4)(iv)(D) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(ii) (which is now codified in the regulations in §412.529(f)(4)(iv)) to reconcile high cost and short stay outlier payments at cost report settlement to account for differences between the cost-to-charge ratio (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.

Finally, we also implemented regulations initially at §412.525(a)(4)(ii) (which is now codified in the regulations at §412.525(a)(4)(iv)(E) for discharges occurring on or after October 1, 2006) and §412.529(c)(5)(ii) (which is now codified in the regulations in §412.529(f)(4)(v)) that at the time of any outlier reconciliation, high cost and short stay outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

IRF PPS

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic inpatient rehabilitation facility (IRF) prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF prospective payment for the case (that is, the case-mix group payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). The unadjusted fixed-loss threshold amount is published annually in the IRF prospective payment system final rule. The regulations governing payments for outlier cases are located at 42 Code of Federal Regulations (CFR) § 412.624(e)(5).

Under 42 CFR § 412.624(e)(5), for discharges occurring on or after October 1, 2003, Medicare contractors use more up-to-date data (that is, data from the most recent tentative settled cost report, whichever is from the later cost reporting period) when determining the cost-to-charge ratio for each hospital (similar to the IPPS policy at §412.84(i)(2)).

Under 42 CFR § 412.624(e)(5), for discharges occurring on or after October 1, 2003, an IRF may contact its FI Medicare contractors to request that its cost-to-charge ratio, otherwise applicable, be changed if the IRF presents substantial evidence that the ratios are inaccurate (similar to the IPPS policy set forth under 412.84(i)(1). Any such requests must be approved by the CMS RO with jurisdiction over that Medicare contractor.

Under 42 CFR § 412.624(e)(5), for discharges occurring on or after October 1, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the cost-to-charge ratio (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.

Finally, according to 42 CFR § 412.624(e)(5), effective for discharges occurring on or after October 1, 2003, IRF outlier payments may be adjusted to account for the time value of any underpayments or overpayments based on the regulations in 42 CFR § 412.84(i), except that CMS calculates a single overall (combined operating and capital) CCR for IRFs and national average IRF CCRs are used instead of statewide average CCRs.

IPF PPS

Section 124 of the Medicare, Medicaid, and SCHIP, Balance Budget Refinement Act of 1999 (BBRA) (Pub.L.106-113), mandated the development of a per diem prospective payment system for inpatient psychiatric services furnished in hospitals and psychiatric distinct part units of acute care hospitals and critical access hospitals. Section 124 of the BBRA provides the Secretary discretion in establishing the payment methodology including payments for cases incurring extraordinarily high costs. This additional payment known as an "outlier" is designed to protect IPFs from large financial losses due to unusually expensive cases. 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 adjustment factors), an additional payment is added to the IPF PPS payment amount.

Under 42 CFR § 412.424(d)(3)(i)(C), for discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors use more up-to-date data (that is, data from the most recent tentatively settled cost report, whichever is from the later cost reporting period) when determining the cost-to-charge ratio for each hospital (similar to the IPPS policy at §412.84(i)(2)).

Under 42 CFR § 412.424(d)(3)(i)(C), for discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may contact its FI Medicare contractors to request that its cost-to-charge ratio, otherwise applicable, be changed if the IPF presents substantial evidence that the ratios are inaccurate (similar to the IPPS

policy set forth under 412.84(i)(1). Any such requests must be approved by the CMS RO with jurisdiction over that Medicare contractor.

Under 42 CFR § 412.424(d)(3)(i)(C), for discharges in cost reporting periods beginning on or after January 1, 2005, high cost outlier payments may be reconciled at cost report settlement to account for differences between the cost-to-charge ratio used to pay the claim at its original submission by the provider, and the cost-to-charge ratio determined at final settlement of the cost reporting period during which the discharge occurred. FIs or MACs will use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later, to obtain the applicable IPF cost-to-charge ratio.

In addition, under 42 CFR § 412.424(d)(3)(i)(C), effective for discharges in cost reporting periods beginning on or after January 1, 2005, at the time of reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

OPPS

Section 1833(t)(5) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for outpatient services furnished when they incur extraordinarily high costs. This additional payment, known as an “outlier,” is designed to mitigate the financial risk associated with extremely costly and complex services. In order to qualify for outlier payments, services must have estimated cost above a fixed-dollar threshold and a multiple threshold, which are published in the annual Outpatient Prospective Payment System final rule. The regulations governing payments for outlier cases are located at 42 CFR 419.43.

Under 42 CFR 419.43(d)(6)(i), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, 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 service was furnished. Since OPPS outlier payments are no longer final payments, CMS will consider reprocessing claims for errors in CCRs or outlier payments on a case by case basis.

In addition, under 42 CFR 419.43(d)(6)(ii), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, at the time of reconciliation under 42 CFR 419.43(d)(6)(i), outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7192.1	As detailed in the Attachment, FISS shall add new fields, identified in bold italics, to the FISS Lump Sum Utility.						X				
7192.1.1	FISS shall update the FISS Lump Sum Utility with all Pricer software from Fiscal Year (FY)/Rate Year (RY) 2003 to present for the IPPS, LTCH PPS and IRF PPS.						X				
7192.1.2	FISS shall update the FISS Lump Sum Utility with all Pricer software from Calendar Year (CY) 2009 to present for the OPPS.						X				
7192.1.3	FISS shall update the FISS Lump Sum Utility with all Pricer software from Rate Year (RY) 2005 to present for the IPF PPS.						X				
7192.1.4	Subsequent to this CR, FISS shall ensure the FISS Lump Sum Utility is kept current (e.g., update the FISS Lump Sum Utility on an ongoing basis whenever an updated version of PRICER is released) for the IPPS, OPPS, IRF PPS, IPF PPS and LTCH PPS.						X				
7192.1.5	FISS shall change the order of operation when calculating the difference between the original and revised payment amounts in the Lump Sum Utility (Note: FISS shall make this change to all the fields titled “Differences Between These Amounts” in the Attachment). Instead of calculating the difference between the original and revised payment amount by subtracting the revised payment amount from the original payment amount (that is the original payment amount minus the revised payment amount), FISS shall calculate the difference between the original and revised payment amount by subtracting the original payment amount from the revised payment amount (that is the revised payment amount minus the original payment amount).						X				
7192.2	Contractors shall test the FISS Lump Sum Utility with a sample of claims from providers paid under the IPPS, LTCH PPS, IRF PPS, IPF PPS and OPPS to ensure that the FISS Lump Sum Utility produces accurate results. For example, contractors shall choose a subset of claims and validate the pricing output for those claims using existing Pricer software testing tools (spreadsheets).	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7192.3	For hospitals paid under the IPF PPS, contractors shall notify the CMS Regional Office (RO) and CMS Central Office (CO) to seek approval to use a CCR based on alternative data if the contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR. [Note: The CMS RO, in conjunction with the CMS CO, must approve the Medicare contractor's request before the contractors may use a CCR based on alternative data.]	X		X							
7192.4	Contractors shall notify the CMS RO and CMS CO if an IPF requests that a different CCR be applied in the event it believes the CCR being applied is inaccurate. Note: The CMS RO, in conjunction with the CMS CO, will approve or deny any request by the IPF for use of a different CCR.	X		X							
7192.5	The contractor shall notify a LTCH or IPF whenever it makes a change to its CCR.	X		X							
7192.5.1	For hospitals paid under the LTCH PPS and IPF PPS, when a CCR is changed as a result of a tentative settlement or a final settlement, contractors shall include the change in the notice that is issued to each provider after a tentative or final settlement is completed. Note: As an alternative, Medicare contractors can also send notification of a change to a LTCH's or IPF's CCR in a separate notice outside of the notice that is issued to each provider after a tentative or final settlement is completed.	X		X							
7192.6	Effective April 1, 2011, for LTCHs, IRFs and IPFs that merge, contractors shall continue to use the CCR from the LTCH, IRF or IPF with the surviving provider number.	X		X							
7192.6.1	Effective April 1, 2011, if a LTCH, IRF or IPF merges with another hospital and a new provider number is issued, contractors shall use the Statewide average CCR for LTCHs or the national average CCR for IPFs because a new provider number indicates the creation of a new hospital. [Note: A hospital or Medicare contractor can request that an alternative CCR be applied to the national or statewide average CCR.]	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7192.7	Medicare contractors shall contact the CMS CO to seek guidance in instances where errors related to CCRs and/or outlier payments are discovered under the LTCH PPS, IRF PPS and IPF PPS,	X		X							
7192.8	Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). In other words, contractors shall never retroactively alter the following fields applicable to the PPS. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS RO or CO. The following fields in the PSF can only be altered on a prospective basis: **For IPPS:** 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 **For LTCH PPS**: 21 -Case Mix Adjusted Cost Per Discharge, 23 -Intern to Bed Ratio, 24 - Bed Size, 25 - Operating Cost to Charge Ratio, 27 - SSI Ratio, 28 - Medicaid Ratio and 49 -Capital IME Ratio. **For IRF PPS**: 21 - Case Mix Adjusted Cost Per Discharge, 24 - Bed Size, 25 -Operating Cost to Charge Ratio, 27 - SSI Ratio, 28 - Medicaid Ratio, and 49 - Capital IME Ratio. **For IPF PPS**: 21 -Case Mix Adjusted Cost Per Discharge, 23 - Intern to Bed Ratio, 24 - Bed Size and 25 -Operating Cost to Charge Ratio. **For OPPS**: Outpatient Cost-to-Charge Ratio Note: 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 (i.e., reprocessing). A separate history outside of the PSF is not necessary.	X		X							
7192.9	For IRFs, Medicare contractors shall apply a national	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	average CCR based on the facility location of either rural or urban in the following situations: 1. New IRFs that have not yet submitted their first Medicare cost report. 2. IRFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. 3. Other IRFs for which accurate data to calculate an overall CCR are not available. Note: The policies of section 140.2.6 part E and F can be applied as an alternative to the national average CCR.										
7192.9.1	For discharges occurring on or after August 8, 2003, the Medicare contractor should use a Statewide average CCR if it is unable to determine an accurate CCR for a LTCH 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. LTCHs whose overall CCR is in excess of 3 standard deviations above the corresponding national geometric mean. Effective 10/1/2006, this mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.525(a)(4)(iv)(c)(2) and 412.529(c)(3)(iv)(c)(2) of the CFR. 3. Other LTCHs for whom accurate data with which to calculate an overall CCR are not available. Note: The policies of section 150.24 part B and C can be applied as an alternative to the Statewide average	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	CCR.										
7192.9.2	For discharges occurring on or after January 1, 2005, Medicare contractors should use the national CCRs for an IPF in one of the following circumstances: 1. New IPFs that have not yet submitted their first Medicare cost report. 2. IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling. 3. Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR. Note: The policy in part F of section 190.7.2.2 can be applied as an alternative to the national average CCR.	X		X							
7192.9.3	For those LTCHs, IRFs and IPFs assigned the national or statewide average CCR, contractors shall update the national or statewide average CCR based on the latest national or statewide average CCRs published in each year's LTCH, IRF and IPF annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report, or an alternative CCR that is approved by the CMS CO.	X		X							
7192.9.4	The Medicare contractor shall update an LTCH, IPF and IRF CCR each time a more recent cost report is settled (either final or tentative).	X		X							
7192.9.5	Revised CCRs shall be entered into the PSF not later than 30 days after the date of the latest settlement used in calculating the CCR.	X		X							
7192.10	If a cost report is reopened after final settlement, and the reopening affects the LTCH's, IRF's or IPF's CCR or outlier payments, contractors shall contact and notify the CMS RO and CO for further instructions.	X		X							
7192.11	For IPFs, effective for cost reporting periods beginning on or after April 1, 2011, subject to the approval of the CMS RO and CO, contractors shall initiate the outlier reconciliation process at the time of cost report final settlement if they meet the following criteria:	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	1. The 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. Total IPF outlier payments in that cost reporting period exceed $500,000.										
7192.12	To determine if a LTCH, IRF or IPF meets the respective criteria of outlier reconciliation, the Medicare contractor shall perform the following steps: (1) incorporate all the adjustments from the cost report, (2) run the cost report, (3) calculate the revised CCR and (4) compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR).	X		X							
7192.12.1	If the criteria are not met, contractors shall finalize the cost report, if appropriate.	X		X							
7192.12.2	If the criteria are met, contractors shall initiate the outlier reconciliation process. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.	X		X							
7192.12.3	If a LTCH or IPF meets the criteria for outlier reconciliation, Medicare contractors shall calculate the amount attributable to the time value of money using the instructions in section 150.27 for LTCHs and section 190.7.2.4 for IPFs.	X		X							
7192.13	Medicare contractors shall have until April 25, 2011 to submit via email a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (Note: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total operating and capital or total high cost and short stay or total outlier payments in the cost reporting period (depending on the PPS being reconciled), the operating CCR or weighted operating CCR or total CCR or weighted total CCR (depending on the PPS being reconciled) from the time the claims were paid during the cost reporting period being reconciled and the final settled operating and capital CCR. Medicare contractors shall submit this list via email to the	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	following email addresses: Hospitals paid under the IPPS and LTCH PPS: outliersipps@cms.hhs.gov Hospitals paid under the IRF PPS-: irf_outlier_reconciliation@cms.hhs.gov Hospitals paid under the OPPS: outliersopps@cms.hhs.gov. Note: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011 shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.										
7192.13.1	The CMS CO shall review this list and grant formal approval for Medicare contractors to re-price and reconcile the claims of those hospitals with open cost reports. Approval will be granted via email by the CMS CO.										CMS
7192.13.2	Contractors shall complete the outlier reconciliation process by October 1, 2011 for provider paid under the IPPS, IRF PPS, LTCH PPS and OPPS that: 1. Were flagged for outlier reconciliation prior to April 1, 2011 and 3. That receive formal approval from CMS (to Medicare contractors) to re-price and reconcile the claims. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS central office for further guidance.	X		X							
7192.14	For providers paid under the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS that meet the criteria for outlier reconciliation, contractors shall follow the procedures in the following sections of the Medicare Claims Processing Manual (Pub. 100-04): IPPS- Chapter 3, Section 20.1.2.7 IRF PPS- Chapter 3. Section 140.2.10 LTCH PPS- Chapter 3, Section 150.28 IPF PPS- Chapter 3, Section 190.7.2.5	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	OPPS- Chapter 4, Section 10.7.2.4										
7192.14.1	Step 1) For hospitals that are eligible for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS, the Medicare contractor shall send notification to the CMS central office (not the hospital) and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital or total high cost and short stay or total outlier payments in the cost reporting period (depending on the PPS being reconciled), the operating CCR or weighted operating CCR or total CCR or weighted total CCR (depending on the PPS being reconciled) from the time the claims were paid during the cost reporting period being reconciled and the final settled operating and capital CCR.	X		X							
7192.14.2	Step 2) If the Medicare contractor receives approval from the CMS central office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 in the appropriate manual section detailing the outlier reconciliation procedures for the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS. NOTE: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.	X		X							
7192.14.3	Step 3) The Medicare contractor 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.	X		X							
7192.14.4	Step 4) For hospitals that are eligible for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS, prior to running claims in the Lump Sum Utility, Medicare contractors shall first update the applicable provider records in the Provider Specific File (PSF). Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the final settled operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the capital CCR in PSF field 47 -Capital Cost to Charge Ratio. For hospitals paid under the IRF PPS, LTCH PPS, IPF PPS and OPPS,	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	Medicare contractors shall enter the final settled CCR in PSF field 25 -Operating Cost to Charge Ratio.										
7192.14.5	Step 4 Continued) Contractors shall ensure that no other elements in the PSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the applicable CCR(s).	X		X							
7192.14.6	Step 5) Prior to reconciling a hospital's outlier claims under the IPPS, LTCH PPS, IRF PPS, IPF PPS and OPPS in the Lump Sum Utility, Medicare contractors shall ensure that all pending claims (e.g., appeal adjustments) are finalized for the applicable provider/hospital.	X		X							
7192.14.7	Step 6) For hospitals that are eligible for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS, and IPF PPS, contractors shall only run claims in the Lump Sum Utility for purposes of outlier reconciliation that meet the following criteria: • Type of Bill (TOB) equals 11X • Previous claim is in a paid status (P location) within FISS • Cancel date is 'blank'	X		X							
7192.14.8	Step 6 Continued) For hospitals and CMHCs that are eligible for outlier reconciliation under the OPPS, contractors shall only run claims in the Lump Sum Utility for purposes of outlier reconciliation that meet the following criteria: • TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07 • Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flag of '0' • Previous claim is in a paid status (P location) within FISS • Cancel date is 'blank'	X		X							
7192.14.9	Step 7) The Medicare contractor reconciles the claims through the applicable Pricer software and not through any editing or grouping software.	X		X							
7192.14.10	Step 8) Upon completing steps 1 through 7 in section	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	20.1.2.7 of Chapter 3 of the CPM for hospitals paid under the IPPS, section 140.2.10 of Chapter 3 of the CPM for hospitals paid under the IRF PPS, section 150.28 of Chapter 3 of the CPM for hospitals paid under the LTCH PPS, section 190.7.2.5 of Chapter 3 of the CPM for hospitals paid under the IPF PPS, and section 10.7.2.4 of Chapter 4 of the CPM for OPPS, the contractor shall run the claims through the FISS Lump Sum Utility. Note: The FISS Lump Sum Utility will produce an extract, according to the elements in Table 1 below. The extract will be importable by Microsoft Access or a similar software program (Microsoft Excel).										
7192.14.11	Step 9) Contractors shall upload the extract (for the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS) from the FISS Lump Sum Utility into Microsoft Access or other software program to generate a report that contains elements shown in the Attachment.	X		X							
7192.14.12	Step 9 Continued) Medicare contractors shall ensure the report that is uploaded into Microsoft Access (or other software program) is retained with the cost report settlement work papers.	X		X							
7192.14.13	Step 10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original operating (value code 17) and capital outlier amount and the revised operating (value code 17) and capital outlier amount. If the difference between the original and revised operating and capital outlier amount is positive, then the contractor shall issue a credit amount to the provider. If the difference between the original and revised operating and capital outlier amount is negative, then the contractor shall issue a debit amount to the provider.	X		X							
7192.14.14	Step 10 Continued) For providers paid under the IRF PPS, IPF PPS and OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then the contractor shall issue a credit amount to the provider. If the difference between the original and revised outlier amount is negative, then the contractor shall issue a	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	debit amount to the provider.										
7192.14.15	Step 10 Continued) For hospitals paid under the LTCH PPS, the difference in the original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short stay and high cost outlier and the revised short stay and high cost outlier. If the balance is positive, then a credit amount shall be issued to the provider. If the balance is negative, then a debit amount shall be issued to the provider by the Medicare contractor.	X		X							
7192.14.16	Step 11) Contractors shall determine the applicable time value of money by using the calculation methodology in the following sections of the claims processing manual: IPPS- Chapter 3, Section 20.1.2.76 IRF PPS- Chapter 3. Section 140.2.9 LTCH PPS- Chapter 3, Section 150.27 IPF PPS- Chapter 3, Section 190.7.2.3 OPPS- Chapter 4, Section 10.7.2.3 If the time value of money is positive, then a credit amount shall be issued to the provider. If the time value of money is negative, then a debit amount shall be issued to the provider. The time value of money can be both a positive or negative amount. Note: For hospitals paid under the IPPS, IRF PPS, IPF PPS and OPPS, the time value of money is applied to the difference between the applicable original outlier amount and the applicable revised outlier amount. For hospitals paid under the LTCH PPS, the time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.	X		X							
7192.14.17	Step 12) For providers paid under the IPPS, for cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (Note: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see section 3630.1 of the Provider Reimbursement Manual, Part II. Note: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.										
7192.14.18	Step 12 Continued) For providers paid under the IPPS, for cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (Note: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. Note: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.	X		X							
7192.14.19	Step 12 Continued) For hospitals paid under the IRF PPS, LTCH PPS and IPF PPS, for cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount (from Worksheet E-3, Part I line 1.05 for the IRF PPS or from Worksheet E-3, Part I line 1.09 for the IPF PPS) or the original PPS amount (by summing lines 1.02 and 1.05 from Worksheet E-3,	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	Part I for the LTCH PPS), the outlier reconciliation adjustment amount, the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (Note: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the manual instructions). The total outlier reconciliation amount (the difference between the original outlier amount and the applicable revised outlier amount plus the time value of money for hospitals paid under the IRF PPS and IPF PPS or the difference between the between the original PPS Payment Amount and Revised PPS Payment Amount plus the time value of money for hospitals paid under the LTCH PPS) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see section 3633.1 of the Provider Reimbursement Manual, Part II.										
7192.14.20	Step 12 Continued) For hospitals paid under the IRF PPS, LTCH PPS and IPF PPS, for cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the revised outlier amount, the original outlier amount (from Worksheet E-3, Part III Line 4 for IRF PPS or from Worksheet E-3, Part II Line 2 for IPF PPS) or the original PPS amount (from Worksheet E-3, Part IV Line 3 for LTCH PPS), the total time value of money and the rate used to calculate the time value of money on lines 50-53 of Worksheet E-3, Part III of the cost report for the IRF PPS, lines 50-53 of Worksheet E-3, Part IV of the cost report for the LTCH PPS and lines 50-53 of Worksheet E-3, Part II of the cost report for the IPF PPS (Note: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the manual instructions) . The total outlier reconciliation amount (the difference between the applicable original outlier amount and the applicable revised outlier amount plus the time value of money for hospitals paid under the IRF PPS and IPF PPS or the difference between the between the original PPS Payment Amount and Revised PPS Payment Amount plus the time value of money for hospitals paid under the LTCH PPS) shall be recorded on line 30 of Worksheet E-3,	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	Part III for the IRF PPS, line 20 of Worksheet E-3, Part IV for the LTCH PPS and line 29 of Worksheet E-3, Part II for the IRF PPS.										
7192.14.21	Step 12 Continued) For hospitals and CMHCs paid under the OPPS, for cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of Worksheet E, Part B of the cost report (Note: the amounts recorded on lines 50, 51, 53 and 54 can be positive or negative amounts per the manual instructions). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines please see section 3630.2 of the Provider Reimbursement Manual, Part II.	X		X							
7192.14.22	Step 12 Continued) For hospitals and CMHCs paid under the OPPS, for cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (Note: the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the manual instructions). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.	X		X							
7192.14.23	Step 13) Upon completing the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS outlier reconciliation process, the contractor shall finalize the cost report, issue a NPR	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	and make the necessary adjustment from or to the provider.										
7192.14.24	Step 14) For providers that are eligible for outlier reconciliation under the IPPS, IRF PPS, LTCH PPS, IPF PPS and OPPS, after completing the outlier reconciliation process, Medicare contractors shall restore the applicable CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 - Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio. For hospitals paid under the IRF PPS, LTCH PPS, IPF PPS and OPPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): For IPPS and LTCH PPS: Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov ; For IRF PPS Susanne Seagrave 410-786-0044 susanne.seagrave@cms.hhs.gov ; For IPF PPS Dorothy Myrick 410-786-9671 dorothy.myrick@cms.hhs.gov ; For OPPS Erick Chuang 410-786-1816 erick.chuang@cms.hhs.gov

Post-Implementation Contact(s): For IPPS and LTCH PPS: Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov ; For IRF PPS Susanne Seagrave 410-786-0044 susanne.seagrave@cms.hhs.gov ; For IPF PPS Dorothy Myrick 410-786-9671 dorothy.myrick@cms.hhs.gov ; For OPPS Erick Chuang 410-786-1816 erick.chuang@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

Attachment

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)

Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.2111, Issued: 12-03-10)

20.1.2 - Outliers

(*Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

§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 *Medicare contractor* using Pricer, which takes into account both operating and capital costs and *Medicare severity*-diagnostic related group (*MS*-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 *MS*-DRGs). Any outlier payment due is added to the *MS*-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 *Medicare contractor* 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. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

For discharges before August 8, 2003, *Medicare contractors* used the latest final settled cost report to determine a hospital's *cost-to-charge ratios* (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 *Medicare contractors* 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, *Medicare contractors* 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.

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 *Medicare contractor*, which includes Medicare allowable costs and charges. The *Medicare contractor* completes 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 *Medicare contractor* 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

Effective August 8, 2003, the *CMS Central Office* may direct *Medicare contractors* to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the *Medicare contractor* 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 *Medicare contractor* 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 *CMS R*egional *O*ffice, in conjunction with the *CMS C*entral *O*ffice, must approve the *Medicare contractor's* request before the *Medicare contractor* may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. *Medicare contractors* shall send notification to the *C*entral *O*ffice 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. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

The *Medicare contractor* shall continue to update a hospital's operating and capital CCRs *(in the Provider Specific File)* 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.

Subject to the approval of CMS, a hospital's operating and/or capital CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all hospital claims processed after the update.

D. Request for use of a Different CCR *by CMS, the Medicare Contractor or the Hospital*

Effective August 8, 2003, CMS (or the *Medicare contractor*) 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 *Medicare contractor* has evaluated the evidence presented by the hospital, the *Medicare contractor* notifies the CMS regional office and CMS Central Office of any such request. The CMS *R*egional *O*ffice, in conjunction with the CMS Central Office, will approve or deny any request by the hospital or *Medicare contractor* for use of a different CCR. *Medicare contractors* shall send requests to the CMS Central Office using the address and email address provided above.

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

The *Medicare contractor* 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. *Medicare contractors* can also issue separate notification to a hospital about a change to their CCR(s).

F. Hospital Mergers, Conversions, and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, *Medicare contractors* shall continue to use the operating and capital CCRs *calculated* from the Medicare cost report associated with the surviving provider number. If a new provider number is issued, as explained in §20.1.2.2 below, *Medicare contractors* 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 *Medicare contractor* 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 *Medicare contractor* must verify the cost and charge data from that cost report. Use of the alternative CCR is subject to the approval of the CMS *C*entral and *R*egional *O*ffices.

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

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

When reprocessing claims due to outlier reconciliation, *Medicare contractors* 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. *The only instances a Medicare contractor retroactively changes a field in the PSF is to update the operating or capital CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.*

20.1.2.2 - Statewide Average Cost-to-Charge Ratios

(*Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

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 *Medicare contractor* 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 *which* 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. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

The *Medicare contractor*, 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 §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/AcuteInpatientPPS/04_outlier.asp#TopOfPage

20.1.2.4 - Transfers

(*Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

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 *a number equal to* 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 §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 §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 *a number equal to* 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 *0.5 multiplied by a number equal to 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 §40.2.4 part C and D.

20.1.2.5 - Reconciliation

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

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 *Medicare contractors* identified using the criteria in §I.A. of PM A-03-058 (under which *Medicare contractors* 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 *C*entral *O*ffice, 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 *Medicare contractor* 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, *Medicare contractors* 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), *Medicare contractors* 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).

Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor 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 Medicare contractor sends notification to the Central Office via the address and email address provided in §20.1.2.1 (b). Upon approval of the CMS Regional and Central Office that a hospital's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §20.1.2.7.

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

As stated above, for a hospital that met the criteria in §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, *Medicare contractors* 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 *Medicare contractors* shall notify the *CMS R*egional *O*ffice 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 *Medicare contractors* 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 *Medicare contractor* shall notify the *CMS R*egional *O*ffice and *C*entral *O*ffice at the address and email address provided in §20.1.2.1. Further instructions for *Medicare contractors* on reconciliation and the time value of money are provided below in §§20.1.2.6 and 20.1.2.7.

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 *Medicare contractor shall notify* the *CMS R*egional *O*ffice and *C*entral *O*ffice. 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, *Medicare contractors* 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 *Medicare contractor* 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 entire 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**

**NOTE: There are 366 days in the year because 2004 was a leap year.*

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.

D. Providers Already Flagged for Outlier Reconciliation

*Medicare contractors shall have until April 25, 2011 to submit via email to outliersipps@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted operating CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled operating and capital CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals that have been flagged for outlier reconciliation. Upon approval from the CMS Central Office, Medicare contractors shall follow the procedures in §20.1.2.7 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011 shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.*

20.1.2.6 - Time Value of Money

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under §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 *Medicare contractor* 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 / *number of days in the cost reporting period*) * # of days from that midpoint until date of reconciliation. ***NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.*

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 *Medicare contractor*, or the date an email was received from the *Medicare contractor* by the CMS Central Office, whichever *date is earlier*.

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

EXAMPLE

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 total outlier payments greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional and Central Office.

The Medicare contractor reprocesses and reconciles 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.*

20.1.2.7 - Procedure for *Medicare Contractors* to Perform and Record Outlier Reconciliation Adjustments

(*Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11*)

The following is a step-by-step explanation of *the procedures that Medicare contractors are to follow if a hospital is eligible for* outlier reconciliation:

1) The *Medicare contractor shall send* notification to the CMS *C*entral *O*ffice (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. *Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.*

2) If the *Medicare contractor* receives approval from the CMS *C*entral *O*ffice that reconciliation is appropriate, the *Medicare contractor* follows steps 3-*14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.*

3) The *Medicare contractor* shall notify the hospital and copy the CMS *R*egional *O*ffice and *C*entral *O*ffice 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) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 -Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being reconciled aside from the elements for the operating and capital CCRs.*

**NOTE: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).*

5) *Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.*

6) *Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:*

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) *The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.*

8) *Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).*

9) *Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.*

10) *For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised operating and capital amounts (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.*

11) *The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the*

applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. ***NOTE****: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.*

12) *For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (****NOTE****: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II.* ***NOTE****: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.*

*For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (****NOTE****: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A.* ***NOTE****: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.*

13) *The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.*

14) *After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 -*

Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the CMS Central Office via the address and email address provided in §20.1.2.1 (B).

***Table 1:** Data Elements for FISS Extract*

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)

Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

140.2.4.4 - Outliers

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

§1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case

equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the **Federal Register**.

140.2.6 - Cost-to-Charge Ratios

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For discharges beginning on and after January 1, 2002 thru September 30, 2003, the Medicare contractor shall use the instructions for calculating the CCR for purposes of determining outlier payments under the IRF PPS set forth in Transmittal A-01-131.

For discharges beginning on or after October 1, 2003, the *Medicare contractor shall* use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period), specific to freestanding IRFs or for IRFs that are distinct part units of acute care hospitals in accordance with the formulas set forth below.

*Effective October 1, 2003, if an IRF's CCR is above the applicable ceiling set forth annually in the IRF PPS notices published in the **Federal Register** it is considered to be statistically inaccurate. As a result, CMS will assign the IRF an appropriate national average CCR. CMS does not use a lower threshold; 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 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 *(PSF)* 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.

The Medicare contractor shall continue to update the IRF's CCR each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the PSF not later than 30 days after the date of the latest settlement used in calculating the CCR.

A - Calculating Medicare CCRs for Freestanding IRFs

1) Identify total Medicare charges from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report

2) Identify total Medicare costs 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.

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

B - Calculating Medicare CCRs for IRF Distinct Part Units

1) Identify Medicare routine costs on Worksheet D-1, Part II, line 41.

2) Identify the result of Worksheet C, Part 1, line 31, column 3 divided by line 31, column 6.

3) Divide Step 1 by Step 2 to compute Medicare routine charges.

4) Identify the result of 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.

5) Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

C - Calculating Medicare CCRs for New IRFs

In the case of a New IRF unit (defined in 42 C.F.R. 412.30) or a New Inpatient Rehabilitation Hospital (defined as a hospital that has never entered into a provider agreement with the Secretary), the Medicare contractor shall use a national average CCR based on the facility location of either urban or rural. The national average CCRs applicable to IRFs shall be found in each year's annual notice of prospective payment rates published in the ***Federal Register.***

The national *average CCR 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*.

We ***NOTE****, the policies in §§ E and F below can be applied as an alternative to the national average CCR.*

For those IRFs assigned the national average CCR, the CCR must be updated every October 1 based on the latest national average CCRs published in each year's IRF PPS annual notice of

prospective payment rates until the IRF is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D- Mergers, Conversion and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IRF with the surviving provider number. If a new provider number is issued (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement), the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

When errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek guidance. Likewise, when a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Medicare contractors should contact the CMS Central Office for further instructions.

E – Alternative CCRs

The CMS may direct the Medicare contractor to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentative settled cost report, if it believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor should contact 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 an IRF's operations occurs which materially affects the IRF's costs and/or charges. Notification to the CMS Central Office shall be sent to the mailing address or email address provided in Part (f) below. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the Medicare contractor for use of an alternative CCR. Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

F – Request for Use of a Different CCR by the IRF

Also, an IRF 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. After the Medicare contractor has evaluated the evidence presented by the IRF, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of such a request. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the IRF for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office at the following address or email address:

CMS
C/O Division of Institutional Post Acute Care

7500 Security Blvd
Mail Stop C5-06-27
Baltimore, MD 21244

irf_outlier_reconciliation@cms.hhs.gov

Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

G - **Notification to Facilities Under the IRF PPS**

The *Medicare contractor shall* notify *an IRF* 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.

H – Maintaining a History of CCRs and Other Fields in the Provider Specific File

When recalculating claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the 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: 21 -Case Mix Adjusted Cost Per Discharge, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio, -28 -Medicaid Ratio and 49 –Capital IME. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

140.2.7- Use of a National Average Cost-to-Charge Ratio

A national average 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 overall CCR is in excess of the national CCR ceiling, as set forth annually in the IRF PPS notices published in the* ***Federal Register****.*
- *Other IRFs for which accurate data to calculate an overall CCR are not available.*

However, the policies of §140.2.6 part E and F can be applied as an alternative to the national average CCR.

*The national urban and rural CCRs for IRFs are set forth annually in the **Federal Register**.*

140.2.8- Reconciling Outlier Payments for IRFs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, Medicare contractors 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.

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, Medicare contractors and the CMS Central Office also have the administrative discretion to reconcile cost reports of those IRFs. However, Medicare contractors must seek approval from the CMS Regional Office and CMS Central Office in the event they intend to reconcile outlier payments for an IRF that does not meet the above-specified criteria.

To determine if an IRF meets the criteria for outlier reconciliation, the Medicare contractor shall perform the following steps: (1) incorporate all the adjustments from the cost report, (2) run the cost report, (3) calculate the revised CCR and (4) compute the actual CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria are not met, the cost report can be finalized. If the criteria are met, Medicare contractors shall follow the instructions in §140.2.10. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

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 IRF PPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Central and Regional Offices for further instructions. Notification to the CMS Central Office shall be sent to the mailing address or email address provided in §140.2.6(F) above.

The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE A:

Cost Reporting Period: 01/01/2010-12/31/2010

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 2007 cost report)

Final settled CCR from 01/01/2010-12/31/2010 cost report: 0.50

Total IRF PPS outlier payout in 01/01/2010-12/31/2010 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 IRF PPS outlier payments during that cost reporting period, the criteria are met for reconciliation, and therefore, the Medicare contractor notifies the CMS Central Office and the Regional Office. The provider's IRF PPS outlier payments for this cost reporting period are reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period to calculate outlier payments, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. Example B below shows how to weight the CCRs. The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if IRF PPS outlier reconciliation is required. Total IRF PPS outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE B:

Cost reporting period: 01/01/2010-12/31/2010

CCR used to pay original claims submitted during cost reporting period:
0.40 from 01/01/2010 to 03/31/2010 (This CCR could be from the tentatively settled 2006 cost report.)

0.50 from 04/01/2010 to 12/31/2010 (This CCR could be from the tentatively settled 2007 cost report.)

Final settled CCR from 01/01/2010 – 12/31/2010 cost report: 0.35

Total IRF outlier payout in 01/01/2010 -12/31/2010 cost reporting period: $600,000

Weighted average CCR: 0.476

CCR	***DAYS***	***Weight***	***Weighted CCR***
0.40	*90*	*0.247 (90 Days / 365 Days)*	*(a) 0.099 = (0.40 * 0.247)*
0.50	*275*	*0.753 (275 Days / 365 Days)*	*(b) 0.377 = (0.50 * 0.753)*
TOTAL	*365*	*365*	*(a)+(b) = 0.476*

The IRF meets the criteria for IRF PPS outlier reconciliation in this cost reporting period because the variance from the weighted average CCR at the time the claim was originally paid compared to the CCR from the cost report at the time of settlement is greater than 10 percentage points (from 0.476 to 0.35) and the provider received total IRF outlier payments greater than $500,000 for the entire cost reporting period.

B. Providers Already Flagged for Outlier Reconciliation

*Medicare contractors shall have until April 25, 2011 to submit via email to irf_outlier_reconciliation@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total outlier payments in the cost reporting period, the CCR or weighted CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals that have been flagged for outlier reconciliation. Upon approval from the CMS Central Office, Medicare contractors shall follow the procedures in §140.2.10 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011, shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.*

140.2.9-Time Value of Money

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

Effective for discharges occurring on or after September 30, 2003, at the time of any reconciliation under §140.2.9.10, 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 IRF's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If the IRF's outlier payments have met the criteria for reconciliation, the Medicare contractor shall follow the process in §140.2.10. 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 / number of days in the cost reporting period) * # of days from that midpoint until date of reconciliation.* ***NOTE****: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.*

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 Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

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

EXAMPLE C:

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%

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 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 Medicare contractor notifies the CMS Regional and Central Office.

The Medicare contractor reprocesses and reconciles 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.*

140.2.10 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IRF is eligible for outlier reconciliation:

1) *The Medicare contractor shall send notification to the CMS Central Office (not the IRF), via the street address or email address provided in §140.2.6 (F), and to the Regional Office that an IRF has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.*

2) *If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.*

3) *The Medicare contractor shall notify the IRF and copy the CMS Regional Office and Central Office in writing or via email (through the addresses provided in §140.2.6 (F)) that the IRF's outlier claims are to be reconciled.*

4) *Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.*

**NOTE: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).*

5) *Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.*

6) *Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:*

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) *The Medicare contractor reconciles the claims through the IRF Pricer software and not through any editing or grouping software.*

8) *Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).*

9) *Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.*

10) *For facilities paid under the IRF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.*

11) *Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §140.2.8. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount, then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount, then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the*

*provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).*

12) *For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.05, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines, see §3633.1 of the Provider Reimbursement Manual, Part II.*

*For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part III, line 4, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part III of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 30 of Worksheet E-3, Part 3.*

13) *The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.*

14) *After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCR(s) used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IRF PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.*

Medicare contractors shall contact the CMS Central Office via the mailing address or email address provided in §140.2.6 (F) with any questions regarding this process.

***Table 1:** Data Elements for FISS Extract*

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number

Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)

Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

150.24 – Determining the Cost to Charge Ratios

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For all LTCHs, effective October 1, 2003, Medicare contractors are to use a CCR from the latest final settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a LTCH's CCR.

A. Calculating an overall LTCH Medicare Cost-to-Charge Ratio

For the LTCH PPS outlier calculations (short stay and high cost), Medicare's portion of hospital costs are determined by using a hospital's overall Medicare cost-to-charge ratio (CCR). At the end of the cost reporting period, the hospital prepares and submits a cost report to its Medicare contractor, which includes Medicare allowable costs and charges. The Medicare contractor completes a preliminary review of the as-submitted cost report and issues a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and a Notice of Program Reimbursement (NPR) is issued.

The Medicare contractor 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).

Under the LTCH PPS, the following methodology shall be used to calculate a hospital's overall Medicare cost-to-charge ratio:

1) Identify total Medicare inpatient costs 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)

2) Identify total Medicare inpatient charges 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).

3) Determine the LTCH's overall Medicare CCR by dividing the amount in step 1 by the amount in step 2.

B. Use of Alternative Data in Determining CCRs For LTCHs

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

CMS
C/O Division of Acute Care- LTCH Outlier Team
7500 Security Blvd
Mail Stop C4-08-06
Baltimore, MD 21244

outliersIPPS@cms.hhs.gov

C. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the LTCH PPS

Medicare contractors shall continue to update a LTCH's CCR (in the Provider Specific File) each time a more recent cost report is settled (either final or tentative). A revised CCR shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

D. Request for use of a Different CCR by CMS, the Medicare Contractor or the LTCH

Effective August 8, 2003, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a LTCH will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The LTCH 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 Medicare contractor has evaluated the evidence presented by the LTCH, the Medicare contractor 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 LTCH or Medicare contractor for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office using the address and email address provided above.

E. Notification to Hospitals Under the LTCH PPS of a Change in the CCR

The Medicare contractor shall notify a LTCH 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. Medicare contractors can also issue separate notification to a LTCH about a change to their CCR.

F. Mergers, Conversions and Errors with CCRs

Effective April 1, 2011, for LTCHs that merge, Medicare contractors shall continue to use the CCR from the LTCH with the surviving provider number. If a new provider number is issued, as explained in §150.25 below, Medicare contractors should use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR §§ 412.525(a)(4)(iv)(C)(1) and 412.529(c)(3)(iv)(C)(1), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). However, the policy of §150.24 part B and C can be applied to determine an alternative to the Statewide average CCR.

For newly classified LTCHs, that is those hospitals (e.g., short term acute, psychiatric, or rehabilitation hospitals) that meet the requirements set forth in 42 CFR 412.23(e), or LTCHs that receive a new LTCH provider number, the Statewide average CCR should be used until a CCR can be computed from the LTCH's cost report data, as described in part A of this section. However, as noted in part C above, the Medicare contractor or the LTCH may request use of a different CCR, such as a CCR based on the cost and charge data from the hospital's cost report immediately preceding its classification as a LTCH or receiving a new LTCH provider number. The Medicare contractor 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. ***NOTE: A newly classified LTCH must request an alternative CCR and receive approval from the CMS Central Office prior to the effective date of the hospital's classification as a LTCH in order for that alternative CCR to be effective beginning on the date of classification (as a LTCH). If the request and approval for an alternative CCR occurs after the effective date of the LTCH classification, then the use of the alternative CCR will be effective prospectively beginning with the date of the approval of the alternative CCR request.***

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek further guidance. Medicare contractors 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, Medicare contractors shall contact the CMS regional and Central Office for

further instructions. Medicare contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

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

*When reprocessing claims due to outlier reconciliation, Medicare contractors 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: 21 -Case Mix Adjusted Cost Per Discharge, 23 -Intern to Bed Ratio, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio and 28 -Medicaid Ratio. A separate history outside of the PSF is not necessary. (**NOTE**: PSF elements 23, 24, 27, 28 and 49 are only required for LTCHs effective 7/11/06.). The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.*

150.25 - Statewide Average Cost-to-Charge Ratios

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For discharges prior to August 8, 2003, the Statewide average CCR is used in those instances in which a LTCH's CCR falls above or below reasonable parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's IPPS annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the Medicare contractor should use a Statewide average CCR if it is unable to determine an accurate CCR for a LTCH 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. *LTCHs whose overall CCR is in excess of 3 standard deviations above the corresponding national geometric mean. Effective 10/1/2006, this mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §§412.525(a)(4)(iv)(c)(2) and 412.529(c)(3)(iv)(c)(2) of the CFR.*
3. *Other LTCHs for whom accurate data with which to calculate an overall CCR are not available.*

However, the policies of §150.24 part B and C can be applied as an alternative to the Statewide average CCR.

For those LTCHs assigned the Statewide average CCR, the CCR must be updated every October 1 based on the latest Statewide average CCRs published in each year's IPPS annual notice of prospective payment rates (Table 8C for LTCHs) 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 §150.24 part B and 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 LTCH CCR is used.

150.26 – Reconciliation

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General

For all LTCHs, 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, Medicare contractors shall reconcile a LTCHs outlier claims at the time of cost report final settlement if they meet the following criteria:

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

2. *High cost outlier payments made under 42 CFR §412.525 and short-stay outlier payments made under 42 CFR §412.529 combined exceed $500,000 in that cost reporting period.*

To determine if a LTCH meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual 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, Medicare contractors shall follow the instructions below in §150.28. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete. The criteria above replaces the criteria published in §III of PM A-03-058.

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), Medicare contractors 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 §150.24 (B).

Even if a LTCH does not meet the criteria for reconciliation, subject to approval of the CMS Regional and Central Office, the Medicare contractor has the discretion to request that a LTCH's outlier payments in a cost reporting period be reconciled if the LTCH's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the CMS Central Office via the address and email address provided in §150.24 (B). Upon approval of the CMS regional and Central Office that a LTCH's high cost and short stay outlier claims need to be reconciled, Medicare contractors shall follow the instructions in §§150.27 and 150.28.

B. Providers Already Flagged for Outlier Reconciliation

*Medicare contractors shall have until April 25, 2011 to submit via email to outliersipps@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals that have been flagged for outlier reconciliation.. Upon approval from the CMS Central Office, Medicare contractors shall follow the procedures in §150.28 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011, shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.*

C. Reconciling Outlier Payments

Beginning with the first cost reporting period starting on or after October 1, 2003, all LTCHs are subject to the reconciliation policies set forth in this section. If a LTCH meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §150.28. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§150.27 and 150.28. The following examples demonstrate how to apply the criteria for reconciliation:

Example A

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

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 CCR from 01/01/2004-12/31/2004 cost report: 0.50.

Total outlier payments (short-stay and high cost outliers combined) 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 (by more than 10 percentage points) at the time of final settlement, and the provider received greater than $500,000 in (short-stay and high cost) outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the Medicare contractor

notifies the CMS Regional Office and CMS Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the actual CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, Medicare contractor shall calculate a weighted average of the CCRs in that cost reporting period. (See Example B below for instructions on how to weight the CCRs). The Medicare contractor shall then compare the weighted average CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total (combined short- stay and high cost) outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

Example B

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

CCR used to pay original claims submitted during cost reporting period:

- *0.40 from 01/01/2004-03/31/2004 (This CCR is from the tentatively settled 2001 cost report)*
- *0.50 from 04/01/2004-12/31/2004 (This CCR is from the tentatively settled 2002 cost report)*

Final settled CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total (short-stay and high cost) outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Weighted Average CCR: 0.474, completed as follows:

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***

*****NOTE****: There are 366 days in the year because 2004 was a leap year.*

The LTCH meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed (by more than ten percentage points) from 0.474 to 0.35 at the time of final settlement, and the provider received (combined) outlier payments greater than $500,000 for the entire cost reporting period.

150.27- Time Value of Money

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

At the time of any reconciliation under §150.26, outlier payments 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 LTCH's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If a LTCH's outlier payments have met the criteria for reconciliation, the Medicare contractor shall follow the process in §150.28. 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 / number of days in the cost reporting period) * # of days from that midpoint until date of reconciliation.* ***NOTE****: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.*

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 Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

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

Example C

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%

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 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 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has total outlier payments greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Regional Office and CMS Central Office.

The Medicare contractor reprices the claims in accordance with the process in §150.28 below. The repricing 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.*

150.28 Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a LTCH is eligible for outlier reconciliation:

1) *The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §150.24 (B)) and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.*

2) *If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below.* ***NOTE****: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.*

3) *The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §150.24 (B)) that the hospital's outlier claims are to be reconciled.*

4) *Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.*

**NOTE: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).*

5) *Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.*

6) *Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:*

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) *The Medicare contractor reconciles the claims through the applicable LTCH Pricer software and not through any editing or grouping software.*

8) *Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).*

9) *Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.*

10) *For hospitals paid under the LTCH PPS, the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short-stay and high cost outlier payment amount and the revised short-stay and high cost outlier payment amount. If the difference between the original and revised PPS Payment Amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised PPS Payment is negative, then a debit amount (deduction) shall be issued to the provider.*

11) *Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount*

(addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. ***NOTE****: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.*

12) *For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original PPS amount by summing lines 1.02 and 1.05 from Worksheet E-3, Part I, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (****NOTE****: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see §3633.1 of the Provider Reimbursement Manual, Part II.*

*For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original PPS amount from Worksheet E-3, Part IV line 3, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part IV of the cost report (****NOTE****: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 20 of Worksheet E-3, Part IV.*

13) *The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.*

14) *After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the LTCH PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.*

If the Medicare contractor has any questions regarding this process it should contact the Central Office, using the address and email address provided in §150.24 (B).

Table 1: *Data Elements for FISS Extract*

List of Data Elements for FISS Extract
Provider #

Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts

Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

190.7.2 - Outlier Policy

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

§124 of the Medicare, Medicaid, and SCHIP, Balance Budget Refinement Act of 1999 (BBRA) (Pub.L.106-113), mandated the development of a per diem prospective payment system for inpatient psychiatric services furnished in hospitals and psychiatric distinct part units of acute care hospitals. §405 (g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(MMA) (Pub. L. 108-173) extended the IPF PPS to distinct part psychiatric units of critical access hospitals (CAHs). §124 of the BBRA provides the Secretary discretion in establishing the payment methodology including payments for cases incurring extraordinarily high costs. This additional payment known as an "outlier" is designed to protect IPFs from large financial losses due to unusually expensive cases. 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 adjustment factors), an additional payment is added to the IPF PPS payment amount.

The fixed dollar loss threshold amount is computed so that projected outlier payments equal 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. *The fixed dollar loss threshold amount is published in the annual IPF PPS update notice or final rule. The specific regulations governing payments for outlier cases are located at 42 CFR 412.424(d) (3) (i).*

Under 42 CFR §412.424 (d)(3)(i), for discharges in cost reporting periods beginning on or after January 1, 2005, high cost outlier payments may be reconciled at cost report settlement to account for differences between the cost-to-charge ratio (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. Medicare contractors will use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later, to obtain the applicable IPF CCR.

In addition, under 42 CFR § 412.424 (d)(3)(i),effective for discharges in cost reporting periods beginning on or after January 1, 2005, at the time of reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based on the regulations in 42 CFR §412.84 (m), except that CMS calculates a single overall (combined operating and capital) CCR for IPFs and national average IPF CCRs are used instead of statewide average CCRs.

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. *For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.hhs.gov/inpatientpsychfacilpps*

Medicare contractors may choose to review outliers if data analysis deems it a priority.

The Pricer program makes all outlier determinations except for the medical review determinations.

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

For discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine the IPF's CCR. 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 CCR.

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 *shall* 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.

- 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 CCR.

A. Use of Alternative Data in Determining CCRs For IPFs Subject to the IPF PPS

Under 42 CFR 412.424(d)(3)(i,), for discharges in cost reporting periods beginning on or after January 1, 2005, CMS may direct Medicare contractors to use an alternative CCR to the CCRs from the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor 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 Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data.

B. Request by the IPF for use of a Different CCR

For discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may request that an alternative CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF 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, in conjunction with the CMS Central Office, will approve or deny any request after evaluation by the Medicare contractor of the evidence presented by the IPF. Revised CCRs are applied prospectively to all IPF claims. Medicare contractors shall send notification to the CMS Central Office via the following address and e-mail address:

CMS
C/O Division of Chronic Care Management-IPF Outlier Team
7500 Security Blvd.
Mail Stop C5-05-27
Baltimore, MD. 21244
outliersipf@cms.hhs.gov

C. Application of National Average CCRs for IPFs

For discharges in cost reporting periods occurring on or after January 1, 2005, the Medicare contractor may use the national CCRs for an IPF in one of the following circumstances:

1. *New IPFs that have not yet submitted their first Medicare cost report.*
2. *IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).*
3. *Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.*

For new IPFs, we are using the national CCRs until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period. ***NOTE****: IPF PPS provides two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.*

The policies in section E below can be applied as an alternative to the national average CCR.

For those IPFs assigned the national average CCR, the CCR must be updated every July 1 based on the latest national average CCRs published in each year's IPF 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 part E and F of this section.

D. Notification to IPFs Under the IPF PPS of a Change in the CCR

The Medicare contractor shall notify an IPF 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. Medicare contractors can also issue separate notification to an IPF about a change to their CCR(s).

E. Ongoing CCR Updates Using CCRs From Tentative Settlements For Entities Subject to the IPF PPS

For discharges beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentatively settled cost report (whichever is from the later period) to determine the IPF's CCR. Under the IPF PPS, Medicare contractors must update the IPFs CCR on the Provider Specific File to reflect the IPFs CCR from the most recent tentative settlements or final settled cost reports, (whichever is the later period). 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 CCR.

Subject to the approval of CMS, an IPF's CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all IPF PPS claims processed after the update.

F. Alternative CCRs

Effective for discharges in cost reporting periods beginning on or after January 1, 2005, the CMS Central Office may direct Medicare contractors to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor 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 Medicare contractor shall contact the CMS Central Office 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 IPF 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 and CMS Central Office must approve any such request after evaluation by the Medicare contractor of the evidence presented by the IPF.

G. IPF Mergers, Ownership Changes, and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IPF with the surviving provider number. If a new provider number (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement) is issued the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact CMS Central Office to seek guidance. Medicare contractors 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, Contractors shall contact the CMS regional and Central Office for further

instructions. Contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

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

When reprocessing claims due to outlier reconciliation, Medicare contractors 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 and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

190.7.2.3 Outlier Reconciliation

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General

Under §412.424 (d) (3) (i), for IPF services furnished during cost reporting periods beginning on or after January 1, 2005, IPF outlier payments may be reconciled upon cost report settlement to account for differences between the overall ancillary 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 service was furnished. IPF PPS outlier payments are reconciled if the CMS Central Office and Regional Office confirm that reconciliation is appropriate.

Effective for cost reporting periods beginning on or after April 1, 2011, subject to the approval of the CMS Central Office and Regional Office, the Medicare contractor shall reconcile an IPF's outlier claims at the time of cost report final settlement if they meet the following criteria:

1. *The 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. *Total IPF outlier payments in that cost reporting period exceed $500,000.*

To determine if an IPF meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR, and compute the actual overall ancillary CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for IPF outlier reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §190.7.2.5 of this chapter. The NPR cannot be issued nor can the cost report be finalized until IPF outlier reconciliation is complete. These IPF cost reports will remain open until their claims have been processed for IPF PPS outlier reconciliation.

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 IPF PPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Central and Regional Offices for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §190.7.2.2(B) above.

Medicare contractors shall notify the CMS Central Office and Regional Office if a cost report was final settled and meets the qualifications for IPF PPS outlier reconciliation. Notification to the CMS Central Office shall be sent to the address and email address provided in §190.7.2.2 (B).

B. Reconciling Outlier Payments IPFs

Beginning with the first cost reporting period starting on or after January 1, 2005, IPF outlier payments may be reconciled at cost report settlement to account for differences between the cost-to-charge ratio (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. Effective for cost reporting periods on or after April 1, 2011, if an IPF meets the criteria in part A of this section, the Medicare contractor shall follow the instructions below in §190.7.2.5. The following examples demonstrate how to apply the criteria for reconciliation (as discussed in part A above):

EXAMPLE A:

Cost Reporting Period: 01/01/2010-12/31/2010

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 2007 cost report)

Final settled operating CCR from 01/01/2010-12/31/2010 cost report: 0.50

Total IPF PPS outlier payout in 01/01/2010-12/31/2010 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 IPF PPS outlier payments during that cost reporting period, the criteria are met for reconciliation, and therefore, the Medicare contractor notifies the Central Office and the Regional Office. The provider's IPF PPS outlier payments for this cost reporting period are reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period to calculate outlier payments, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. Example B below shows how to weight the CCRs. The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of

the cost reporting period to determine if IPF PPS outlier reconciliation is required. Total IPF PPS outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE B:

Cost reporting period: 01/01/2010-12/31/2010

Overall CCR used to pay original claims submitted during cost reporting period:

0.40 from 01/01/2010 to 03/31/2010 (This CCR could be from the tentatively settled 2006 cost report.)

0.50 from 04/01/2010 to 12/31/2010 (This CCR could be from the tentatively settled 2007 cost report.)

Final settled operating CCR from 01/01/2010 – 12/31/2010 cost report: 0.35

Total IPF outlier payout in 01/01/2010 -12/31/2010 cost reporting period: $600,000

Weighted average CCR: 0.476

CCR	***DAYS***	***Weight***	***Weighted CCR***
0.40	*90*	*0.247 (90 Days / 365 Days)*	*(a) 0.099 = (0.40 * 0.247)*
0.50	*275*	*0.753 (275 Days / 365 Days)*	*(b) 0.377 = (0.50 * 0.753)*
TOTAL	*365*	*365*	*(a)+(b) = 0.476*

The IPF meets the criteria for IPF PPS outlier reconciliation in this cost reporting period because the variance from the weighted average CCR at the time the claim was originally paid compared to the CCR from the cost report at the time of settlement is greater than 10 percentage points (from 0.476 to 0.35) and the provider received total IPF outlier payments greater than $500,000 for the entire cost reporting period.

Even if the IPF does not meet the criteria for reconciliation in §190.7.2.3, subject to approval of the CMS Central and Regional Offices, the Medicare contractor has the discretion to request that IPF PPS outlier payments in a cost reporting period be reconciled if the IPF's most recent cost and charge data indicate that the IPF PPS outlier payments to the IPF were significantly inaccurate. The Medicare contractor sends notification to the CMS Regional Office and Central Office via the address and email address provided in §190.7.2.2 (B). Upon approval of the CMS

Central and Regional Office that IPF's outlier claims need to be reconciled, Medicare contractors should follow the instructions in §190.7.2.3.

190.7.2.4. Time Value of Money

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

Effective for discharges occurring on or after January 1, 2005, at the time of any reconciliation under §190.7.2, IPF outlier payment may be adjusted to account for the time value of money of any adjustments to IPF outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the IPF's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If an IPF's outlier payments have met the criteria for reconciliation, Medicare contractors 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 shall 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 / number of days in the cost reporting period) * # of days from that midpoint until date of reconciliation.* ***NOTE****: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.*

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 Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

EXAMPLE C:
Cost reporting period: 01/01/2010 – 12/31/2010
Midpoint of cost reporting period: 07/01/2010
Date of reconciliation: 12/31/2010
Number of days from midpoint until date of reconciliation: 547

Rate from Social Security Web site: 4.625%

Overall ancillary CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2006 or 2007 cost report.)

Final settled operating CCR from 01/01/2009 – 12/31/2009 cost report: 0.50

Total IPF outlier payout in 01/01/2009 – 12/31/2009 cost reporting period: $600,000

Because the CCR fluctuated from 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an IPF outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor follows the procedures in §190.7.2.4.

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The reprocessing of claims indicates the revised IPF hospital outlier payments are $700,000.

Using the values above, the rate that is used for the time value of money is determined:
*(4.625 / 365) * 548 = 6.9438%*

Based on the claims reconciled, the provider is owed $100,000 ($700,000 - $600,000) for the reconciled amount and $6,943.80 for the time value of money.

190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IPF is eligible for outlier reconciliation:

1) *The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §190.7.2.2 (B), and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.*

2) *If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below.* ***NOTE****: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.*

3) *The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §190.7.2.2 (B)) that the hospital's outlier claims are to be reconciled.*

4) *Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.*

**NOTE: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).*

5) *Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.*

6) *Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:*

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) *The Medicare contractor reconciles the claims through the IPF Pricer software and not through any editing or grouping software.*

8) *Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).*

9) *Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.*

10) *For hospitals paid under the IPF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider.*

11) *Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §190.7.2.4. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the*

*provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).*

12) *For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.09, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines please see § 3633.1 of the Provider Reimbursement Manual, Part II.*

    *For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part II line 2, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part II of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 29 of Worksheet E-3, Part II.*

13) *The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.*

14) *After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPF PPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.*

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §190.7.2.2 (B) with any questions regarding this process.

***Table 1:** Data Elements for FISS Extract*

List of Data Elements for FISS Extract
Provider #

Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)

Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

10.7.2.1 - Identifying Hospitals and CMHCs Subject to Outlier Reconciliation

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General

Under §419.43(d)(6)(i), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, OPPS high cost outlier payments may be reconciled upon cost report settlement to account for differences between the overall ancillary 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 service was furnished. Hospitals and CMHCs that Medicare contractors identify using the criteria listed below are subject to the OPPS outlier reconciliation policies described in this section. OPPS outlier payments are reconciled if the CMS *C*entral *O*ffice and *R*egional *O*ffice confirm that reconciliation is appropriate. Services with an APC payment paid at charges adjusted to cost are not subject to reconciliation policies.

Subject to the approval of the CMS *C*entral *O*ffice and *R*egional *O*ffice, a hospital's outpatient outlier claims are reconciled at the time of cost report final settlement if they meet the following criteria:

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

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

Subject to the approval of the CMS *C*entral *O*ffice and *R*egional *O*ffice, a CMHC's outlier claims are reconciled at the time of cost report final settlement if they meet the following criteria:

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

2. Any CMHC OPPS outlier payments are made in that cost reporting period.

To determine if a hospital or CMHC meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR, and compute the actual overall ancillary CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for OPPS outlier reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §10.7.2.4 of this chapter. The NPR cannot be issued nor can the cost report be finalized until OPPS outlier reconciliation is complete. These hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

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 OPPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS *C*entral and *R*egional *O*ffices for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §10.11.3.1.

Any cost report that has been final settled that meets the qualifications for OPPS outlier reconciliation shall be reopened. Medicare contractors shall notify the CMS Central Office and *R*egional *O*ffice that the OPPS outlier payments need to be reconciled, using the procedures included in §10.7.2.4. After CMS' approval of the reconciliation, the Medicare contractor shall issue a reporting notice to the provider.

B. Hospitals and CMHCs Already Flagged for Outlier Reconciliation

*Medicare contractors shall have until April 25, 2011 to submit via email to outliersopps@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total outlier payments in the cost reporting period, the CCR or weighted CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals with open cost reports. Upon receiving approval for reconciliation from the CMS Central Office, Medicare contractors shall follow the procedures in §10.7.2.4 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011 shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.*

10.7.2.3 - Time Value of Money

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

Effective for hospital outpatient services furnished in the first cost reporting period on or after January 1, 2009, at the time of any reconciliation under §10.7.2.2, OPPS outlier payment may be adjusted to account for the time value of money of any adjustments to OPPS outlier payments as a result of reconciliation. As described in 42 CFR 419.43(d)(6)(ii), the time value of money is applied from the midpoint of the hospital or CMHC's cost reporting period being settled to the date on which the CMS *C*entral *O*ffice receives notification from the Medicare contractor that reconciliation should be performed.

If a hospital or CMHC's OPPS 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 is 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 is 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 / *number of days in the cost reporting period*) * # of days from that midpoint until date of reconciliation. ***NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.*

For purposes of calculating the time value of money, the “date of reconciliation” is the day on which the CMS *C*entral *O*ffice receives notification. This "date of reconciliation" is based solely on the date CMS *C*entral *O*ffice receives notification and not on the date that reconciliation is approved by the CMS *C*entral and *R*egional *O*ffices. This date is either the postmark from the written notification sent to the CMS *C*entral *O*ffice via mail by the Medicare contractor, or the date an email was received from the Medicare contractor by the CMS *C*entral *O*ffice, whichever is first.

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

EXAMPLE:

Cost reporting period: 01/01/2009 – 12/31/2009

Midpoint of cost reporting period: 07/01/2009

Date of reconciliation: 12/31/2010

Number of days from midpoint until date of reconciliation: 548

Rate from Social Security Web site: 4.625%

Overall ancillary CCR used to pay actual original claims in cost reporting period: 0.40
(This CCR could be from the tentatively settled 2006 or 2007 cost report.)

Final settled operating CCR from 01/01/2009 – 12/31/2009 cost report: 0.50
Total OPPS outlier payout in 01/01/2009 – 12/31/2009 cost reporting period: $600,000

Because the CCR fluctuated from 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an OPPS outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the *CMS C*entral and *R*egional *O*ffices.

The Medicare contractor reprices the claims in accordance with the process in §10.7.2.4 below. The repricing indicates the revised outlier payments are $700,000.

Using the values above, the rate that is used for the time value of money is determined:

(4.625 / 365) * 548 = 6.9438%

Based on the claims reconciled, the provider is owed $100,000 ($700,000 - $600,000) for the reconciled amount and $6,943.80 for the time value of money.

10.7.2.4 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation *of the procedures that Medicare contractors are to follow if a* hospital (or CMHC) *is eligible for outlier* reconciliation*:*

1) The Medicare contractor sends notification to the CMS *C*entral *O*ffice (not the hospital or CMHC), via the street address and email address provided in §10.11.3.1 and to the *CMS R*egional *O*ffice that a hospital or CMHC has met the criteria for OPPS outlier reconciliation. *Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.*

2) If the Medicare contractor receives approval from the CMS *C*entral *O*ffice and *R*egional *O*ffice that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-*14* below. ***NOTE****: Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.*

3) The Medicare contractor shall notify the hospital or CMHC and copy the CMS *R*egional *O*ffice and *C*entral *O*ffice in writing and via email (through the address provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.

4) Prior to running claims in the FISS Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Outpatient Provider Specific File (OPSF) by entering the final settled CCR from the cost report in Outpatient Cost to Charge Ratio field. No other elements in the OPSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.*

**NOTE: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).*

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) *Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:*

- *TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07*
- *Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flag of '0'*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) *The Medicare contractor reconciles the claims through the OPPS Pricer software and not through any editing or grouping software.*

8) *Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below.* ***NOTE****: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).*

9) *Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.*

10) *For hospitals paid under the OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.*

11) *Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §10.7.2.3. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider.* ***NOTE****: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).*

12) *For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of*

*Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 50, 51, 53 and 54 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines see §3630.2 of the Provider Reimbursement Manual, Part II.*

*For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.*

13) *The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.*

14) *After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the OPPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.*

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §10.11.3.1 with any questions regarding this process.

***Table 1:** Data Elements for FISS Extract*

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)

Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG

MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

10.11.11 - Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The contractors shall report the OPPS hospital overall or CMHC CCR they calculate, or the Statewide CCR they select, for each provider to the Outpatient Provider Specific File (OPSF; see §50.1 of this chapter) within 30 days after the date of the calculation or selection of the Statewide CCR for the provider. If a cost report reopening results in adjustments that would change the CCR that is currently in effect, the contractor shall calculate and enter the CCR in the OPSF within 30 days of the date that the reopening is finalized. In such an instance, contractors must create an additional record in the OPSF for the provider. The contractor entries in the OPSF shall include the effective date of the CCR being entered. Entries in the OPSF shall not replace a pre-existing entry for the provider. *The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.*