CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11113	**Date: November 16, 2021**
	Change Request 12512

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Sections 90.1.2, 90.3, 90.3.1, and Addendum A Provider Specific File

I. SUMMARY OF CHANGES: This Change Request (CR) updates Chapter 3 Inpatient Hospital Billing, Sections 90.1.2 Billing for Kidney Transplant and Acquisition Services, 90.3. Stem Cell Transplantation, 90.3.1 Allogeneic for Stem Cell Transplantation and Addendum A Provider Specific File of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: December 17, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2021

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/Addendum A/ Provider Specific File
R	3/ 90/ 90.1.2 / Billing for Kidney Transplant and Acquisition Services
R	3/ 90/ 90.3/Stem Cell Transplantation
R	3/ 90/ 90.3/ 90.3.1/ Allogeneic for Stem Cell Transplantation

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11113	Date: November 16, 2021	Change Request: 12512

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Sections 90.1.2, 90.3, 90.3.1, and Addendum A Provider Specific File

EFFECTIVE DATE: December 17, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2021

I. GENERAL INFORMATION

A. Background: IOM Revisions for Allogeneic Stem Cell Acquisition Charges

Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), provides that, effective for cost reporting periods beginning on or after October 1, 2020, costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant are not included in the definition of "operating costs of inpatient hospital services" at section 1886(a)(4) of the Act. In addition, section 108 of the Further Consolidated Appropriations Act, 2020 provides that in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis. This is the same way hospitals with approved transplant centers are reimbursed for their acquisition costs for solid organs under 42 CFR 412.113(d).

This Change Request (CR) also updates language regarding the reimbursement of costs for Allogeneic Stem Cell acquisition charges through the cost reporting process in the Medicare Claims Processing Manual Pub. 100-04, Chapter 3, Sections 90.3 and 90.3.1. This CR also updates Addendum A - Provider Specific File to add data element 65- Pass Through Amount for Allogeneic Stem Cell Acquisition.

IOM Revisions for Long Term Care Hospital (LTCH)

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. This revision to payments under the existing LTCH PPS established two separate payment rates for LTCH discharges: cases meeting specific clinical criteria are paid the LTCH standard Federal payment; and those cases not meeting specific clinical criteria are paid the "site neutral" rate, i.e., the lesser of an "IPPS-comparable" payment amount or 100 percent of the estimated cost of the case. The payment changes were implemented through a Blend Transition period under CR 9015 *Implementation of Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Based on Specific Clinical Criteria.*

The statute originally established a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during Fiscal Year (FY) 2016 or FY 2017, which was extended by subsequent legislation to cost reporting periods beginning during FY 2018 and FY 2019. The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH standard Federal payment rate.

This transitional blended payment rate for site neutral rate LTCH discharges is included in the Pricer logic, and MACs shall ensure that the Fiscal Year Beginning Date field in the Provider Specific File (PSF) (Data Element 4, Position 25) is updated as applicable with the correct date.

This CR updates IOM Pub. 100-04, Chapter 3, Addendum A - Provider Specific File to update the definitions of data element 18- Federal PPS Blend Indicator, for LTCHs, for the Blend Transition Period data elements. This CR also includes an update for the definitions of data element 64- Supplemental Wage

Index Flag, applicable to LTCH providers.

MACs shall ensure that for LTCH cost reporting periods beginning during FY 2020, the blend year indicator is set to "8". In particular, MACs shall ensure the blend year indicator is set to "8" beginning with each LTCH's cost reporting period that begins on or after October 1, 2019.

IOM Revisions for Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions in Maryland Waiver (MW) Hospitals for Medicare Advantage (MA) Beneficiaries

In 2019, the State of Maryland and the Innovation Center launched the Maryland Total Cost of Care (TCOC) Model to continue the statewide care transformation initiated under the previous Maryland All-Payer Model. Under the TCOC Model, Maryland continues to set hospital global budgets on an all-payer basis. Hospitals have the authority to increase or decrease charges to all payers for a given service within prescribed corridors to achieve their approved global budget amount. Hospitals may adjust their rates 5 percent above or below the approved rates without seeking permission from the Health Services Cost Review Commission (HSCRC), and can request permission from the HSCRC to make rate adjustments of up to 10 percent above or below their approved rates. The hospitals are required to charge an identical amount to commercial payers and to public payers, including Medicare; however, as a stipulation of the public payer differential public payers pay 7.7 percent less than other payers.

Under the Hospital Payment Program, hospital payments are made in real time for hospital services based on the global budgets set by the HSCRC. Instead of determining the payment amount of the claim through Inpatient Prospective Payment System (IPPS) or Outpatient Prospective Payment System (OPPS) payment systems, CMS pays the claim at 92.3 percent of the charge plus adjustments for sequestration. After the calendar year is over, the HSCRC conducts a retrospective reconciliation with the hospital's TCOC and adjusts the hospital's global budget for the following rate year in order to hold the hospital accountable for meeting its global budget and to create a disincentive for exceeding it. Maryland hospitals file cost reports that are generally for information only purposes, and does not result in a cost report settlement.

Effective January 1, 2021, the Calendar Year (CY) 2021 Medicare Parts C & D final rule (85 FR 33796, 33824) specifies that Medicare will now cover kidney acquisition cost for Medicare Advantage beneficiaries. Under Medicare FFS, final payment for kidney acquisition costs will be made to the hospital through the Medicare cost report. Maryland Waiver hospitals currently include kidney acquisition charges along with other solid organ acquisition charges with the applicable organ transplant charges and are paid at 92.3 percent of those charges and not reimbursed through the Medicare cost report.

To comply with policy requirements for identifying charges specific to kidney acquisition from other solid organ for purposes of tracking and payment, the National Uniform Billing Committee (NUBC) created Value Code '91'- Charges for Kidney Acquisition, effective October 1, 2021. Change Request (CR) 12206 *Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions in Maryland Waiver (MW) Hospitals for Medicare Advantage (MA) Beneficiaries*, implemented the payment mechanism and systems updates needed to ensure that kidney acquisition charges are appropriately tracked and paid at 92.3 percent, subject to sequestration.

This CR adds language and billing instructions for MW Hospitals in Section 90.1.2- Billing for Kidney Transplant and Acquisition Services.

IOM Revisions for Low Volume Adjustment Factor

The low-volume adjustment factor shall be calculated in accordance with the extension provided by amendments by the Affordable Care Act and subsequent legislative changes to the Bipartisan Budget Act of 2018. In accordance with the existing regulations at § 412.101(b)(2)(ii), this CR adds clarification for the Provider Specific File, data element 59 -LV Adjustment Factor, for changes in the low-volume hospital payment policy applicable for FYs 2018 and after.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12512.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Sections 90.1.2, 90.3, 90.3.1 and Addendum A- Provider Specific File.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Yvette Rivas, Yvette.Rivas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 11113; Issued: 11-16-21; Effective: 12-17-21; Implementation: 12-17-21)

Applicable standard kidney acquisition charges are identified separately by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not** included in the kidney transplant prospective payment. They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Effective January 1, 2021, the Calendar Year (CY) 2021 Medicare Parts C & D final rule (85 FR 33796, 33824) specifies that Medicare will now cover kidney acquisition cost for Medicare Advantage beneficiaries. Under Medicare FFS, final payment for kidney acquisition cost will be made to the hospital through the Medicare cost report. Maryland Waiver hospitals currently include kidney acquisition charges along with other solid organ acquisition charges with the applicable organ transplant charges and are paid at 92.3 percent of those charges and not reimbursed through the Medicare cost report.

Effective for dates of admission on or after January 01, 2021, Maryland Waiver (MW) hospitals shall submit the applicable standard kidney acquisitions charges with Value Code '91'- Charges for Kidney Acquisition- when submitting informational only claims for Medicare Advantage beneficiaries. MW hospitals shall submit this value code in addition to reporting Condition Code 04, and the applicable standard acquisition charges under revenue codes 0811 or 0812 as appropriate. The contractor shall separately reimburse these costs as an add-on payment under the current payment rate of 92.3 percent of the reported charges, subject to sequestration reduction.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for kidney transplant procedure codes. Where these procedure codes are identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

90.3 - Stem Cell Transplantation

(Rev. 11113; Issued: 11-16-21; Effective: 12-17-21; Implementation: 12-17-21)

A. General

Stem cell transplantation is a process in which stem cells are harvested from either a patient's (autologous) or donor's (allogeneic) bone marrow or peripheral blood for intravenous infusion. Autologous stem cell *transplantation (AuSCT) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT* must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic hematopoietic stem *cell transplantation (HSCT) is a procedure in which a portion of a healthy donor's stem cell or bone marrow is obtained and prepared for intravenous infusion. Effective for cost reporting periods beginning on or after October 1, 2020, for subsection (d) hospitals (that is, hospitals paid under the IPPS) furnishing an allogeneic hematopoietic stem cell transplant, such transplant is defined, in accordance with Section 108 of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94), as the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.*

Allogeneic HSCT may be used to restore function in recipients having an inherited or acquired deficiency or defect. Hematopoietic stem cells are multi-potent stem cells that give rise to all the blood cell types; these stem cells form blood and immune cells. A hematopoietic stem cell is a cell isolated from blood or bone marrow that can renew itself, differentiate to a variety of specialized cells, can mobilize out of the bone marrow into circulating blood, and can undergo programmed cell death, called apoptosis - a process by which cells that are unneeded or detrimental will self-destruct.

The Centers for Medicare & Medicaid Services (CMS) is clarifying that bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. Effective October 1, 1990 *through September 30, 2010*, these cases were assigned to MS-DRG 009, Bone Marrow Transplant. *Effective October 1, 2010, MS-DRG 009 was deleted and two new separate MS-DRGs were created: MS-DRG 014 (Allogeneic Bone Marrow Transplant) and MS-DRG 015 (Autologous Bone Marrow Transplant). Effective October 1, 2011, Autologous Bone Marrow Transplant was subdivided into two severity levels, deleting MS-DRG 015 and creating two new MS-DRGs: MS–DRG 016 (Autologous Bone Marrow Transplant with CC/MCC); and MS-DRG 017 (Autologous Bone Marrow Transplant without CC/MCC).*

The A/B MAC (A)'s Medicare Code Editor (MCE) will edit stem cell transplant procedure codes against diagnosis codes to determine which cases meet specified coverage criteria. Cases with a diagnosis code for a covered condition will pass (as covered) the MCE noncovered procedure edit. When a stem cell transplant case is selected for review based on the random selection of beneficiaries, the QIO will review the case on a post-payment basis to assure proper coverage decisions.

Bone marrow transplant codes that are reported with an ICD-9-CM that is "not otherwise specified" are returned to the hospital for a more specific procedure code. ICD-10-PCS codes are more precise and clearly identify autologous and nonautologous stem cells.

The A/B MAC (A) may choose to review if data analysis deems it a priority.

B. Nationally Covered Indications

I. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

a. General

Allogeneic stem cell transplantation (ICD-9-CM Procedure Codes 41.02, 41.03, 41.05, and 41.08 *on or before 9/30/2015*; ICD-10-PCS codes 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, and 30263Y1 *as of October 1, 2015*) is a procedure in which a portion of a healthy donor's stem cells are obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect. See Pub. 100-03, National Coverage Determinations (NCD) Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding. *For the latest ICD-10-PCS codes defining MS-DRG 014 for allogeneic stem cell transplants, see the ICD-10-CM/PCS MS-DRG Definitions Manual, available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.*

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, *we*re not paid separately. *Effective for cost reporting periods beginning on or after October 1, 2020, a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual during such a period, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis.*

Services to the donor include physician services, hospital care in connection with screening the *donor's* stem cell*s*, and ordinary follow-up care. *For a detailed listing of items comprising allogeneic hematopoietic stem cell acquisition costs, see section 90.3.1.A. of this chapter.*

b. Covered Conditions

i. **Effective for services performed on or after August 1, 1978:**

For the treatment of leukemia, leukemia in remission, or aplastic anemia when it is reasonable and necessary;

ii. **Effective for services performed on or after June 3, 1985:**

For the treatment of severe combined immunodeficiency disease (SCID), and for the treatment of Wiskott-Aldrich syndrome;

iii. **Effective for services performed on or after August 4, 2010:**

For the treatment of Myelodysplastic Syndromes (MDS) pursuant to Coverage with Evidence Development (CED) in the context of a Medicare-approved, prospective clinical study.

iv. **Effective for claims with dates of service on or after January 27, 2016:**

1. Allogeneic HSCT for multiple myeloma is covered by Medicare only for beneficiaries with Durie-Salmon Stage II or III multiple myeloma, or International Staging System (ISS) Stage II or Stage III multiple myeloma, and participating in an approved prospective clinical study.

2. Allogeneic HSCT for myelofibrosis (MF) is covered by Medicare only for beneficiaries with Dynamic International Prognostic Scoring System (DIPSSplus) intermediate-2 or High primary or secondary MF and participating in an approved prospective clinical study.

3. Allogeneic HSCT for sickle cell disease (SCD) is covered by Medicare only for beneficiaries with severe, symptomatic SCD who participate in an approved prospective clinical study.

II. Autologous Stem Cell Transplantation (AuSCT)

a. General

Autologous stem cell transplantation (ICD-9-CM Procedure Codes 41.01, 41.04, 41.07, and 41.09; ICD-10-PCS codes 30230AZ, 30230G0, 30230Y0, 30233G0, 30233Y0, 30240G0, 30240Y0, 30243G0, 30243Y0, 30250G0, 30250Y0, 30253G0, 30253Y0, 30260G0, 30260Y0, 30263G0, and 30263Y0) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

b. Covered Conditions

1. Effective for services performed on or after April 28, 1989:

Acute leukemia in remission who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched;

Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response;

Recurrent or refractory neuroblastoma; or,

Advanced Hodgkin's disease who have failed conventional therapy and have no HLA-matched donor.

2. Effective for services performed on or after October 1, 2000:

Single AuSCT is only covered for Durie-Salmon Stage II or III patients that fit the following requirements:

- Newly diagnosed or responsive multiple myeloma. This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse; and

- Adequate cardiac, renal, pulmonary, and hepatic function.

3. Effective for services performed on or after March 15, 2005:

When recognized clinical risk factors are employed to select patients for transplantation, high dose melphalan (HDM) together with AuSCT is reasonable and necessary for Medicare

beneficiaries of any age group with primary amyloid light chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and,
- Cardiac left ventricular ejection fraction (EF) greater than 45%.

C. Nationally Non-Covered Indications

I. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

Effective for claims with dates of service on or after May 24, 1996, *through January 26, 2016,* allogeneic HSCT is not covered as treatment for multiple myeloma. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

II. Autologous Stem Cell Transplantation (AuSCT)

Insufficient data exist to establish definite conclusions regarding the efficacy of AuSCT for the following conditions:

a) Acute leukemia not in remission;
b) Chronic granulocytic leukemia;
c) Solid tumors (other than neuroblastoma);
d) Up to October 1, 2000, multiple myeloma;
e) Tandem transplantation (multiple rounds of AuSCT) for patients with multiple myeloma;
f) Effective October 1, 2000, non primary AL amyloidosis; and,
g) Effective October 1, 2000, through March 14, 2005, primary AL amyloidosis for Medicare beneficiaries age 64 or older.

In these cases, AuSCT is not considered reasonable and necessary within the meaning of §l862(a)(1)(A) of the Act and is not covered under Medicare. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.23, for further information about this policy, and Pub. 100-04, chapter 32, section 90, for information on coding.

D. Other

All other indications for stem cell transplantation not otherwise noted above as covered or non-covered remain at local Medicare Administrative Contractor discretion.

90.3.1 - Allogeneic for Stem Cell Transplantation

(Rev. 11113; Issued: 11-16-21; Effective: 12-17-21; Implementation: 12-17-21)

A. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

1. Effective for Cost Reporting Periods Beginning Prior to October 1, 2020

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting, and in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the outpatient setting.

The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 4, §231.10 and paragraph B of this section for information regarding billing for autologous stem cell transplants).

2. Effective for Cost Reporting Periods Beginning On or After October 1, 2020

Allogeneic hematopoietic stem cell acquisition costs are as follows:

- *Registry fees from a national donor registry described in 42 U.S.C. 274k, if applicable, for stem cells from an unrelated donor.*
- *Tissue typing of donor and recipient.*
- *Donor evaluation.*

- *Physician pre-admission/pre-procedure donor evaluation services.*

- *Costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services), and transportation costs of stem cells if the recipient hospital incurred or paid such costs.*

- *Post-operative/post-procedure evaluation of donor.*

- *Preparation and processing of stem cells derived from bone marrow, peripheral blood stem cells, or cord blood (but not including embryonic stem cells).*

Effective for cost reporting periods beginning on or after October 1, 2020, a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual during such a period, payment to such hospital for hematopoietic stem cell acquisition shall be made on a reasonable cost basis.

Payment for allogeneic hematopoietic stem cell acquisition services continues to be included in the OPPS APC payment when the transplant occurs in the outpatient setting.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 4, §231.10 and paragraph B of this section for information regarding billing for autologous stem cell transplants).

B. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 4, §231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.

When the allogeneic stem cell transplant occurs in the inpatient setting, allogeneic bone marrow/stem cell *acquisition charges shall be billed using revenue code 0815*. Revenue code 0815 *(Allogeneic Stem Cell Acquisition/Donor Services)* charges should include all services required to acquire stem cells from a donor, as defined above. *Effective for discharges occurring on or after October 1, 2021, such charges are not considered for the IPPS outlier calculation when billed for an allogeneic stem cell transplant.*

On the recipient's transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished *in collecting allogeneic hematopoietic stem cells including all invoices or statements for purchased services for all donors and their service charges. Records must be for* the person receiving the service (donor *or* recipient). *Beginning October 1, 2020, for all donor sources, the hospital must identify the prospective recipient and include the recipient's Medicare beneficiary identification number.* These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition

services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. *The hospital shows charges for acquiring allogeneic hematopoietic stem cells for transplant in revenue code 0815.*

Addendum A - Provider Specific File

(Rev. 11113; Issued: 11-16-21; Effective: 12-17-21; Implementation: 12-17-21)

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>1</td><td>1-10</td><td>X(10)</td><td>National Provider Identifier (NPI)</td><td>Alpha-numeric 10 character NPI number.</td></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital

Data Element	File Position	Format	Title	Description
				(during cost reporting periods that began on or after April 1, 1990). 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is

Data Element	File Position	Format	Title	Description
				reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a "Y" if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a "Y" if the provider is considered "low volume." **IPF PPS**: Effective January 1, 2005, code a "Y" if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a "Y" for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage **LTCH PPS:** Effective 04/21/16 through 12/31/16, code a 'Y' for an LTCH that is a grandfathered HwH (hospitals that are described in § 412.23(e)(2)(i) that currently meets the criteria of § 412.22(f)); and is located in a rural area or is reclassified rural by meeting the provisions outlined in §412.103, as set forth in the regulations at §412.522(b)(4).
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** For "From" dates before 1/1/2021: Enter the value to indicate if normal percentage payments should be made on RAP and/or whether payment

Data Element	File Position	Format	Title	Description
				should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 1 = Pay 0% 2 = Make final payment reduced by 2% 3 = Make final payment reduced by 2%, pay RAPs at 0% NOTE: All new HHAs enrolled after January 1, 2019 must have this value set to 1 or 3 (no RAP payments). For "From" dates on or after 1/1/2021: Enter the value to indicate whether payment should be reduced under the Quality Reporting Program. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2% **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** *For cost reporting periods beginning on or after 10/01/2002, enter the appropriate code for the blend ratio between federal and facility rates for the LTCH provider:* 1 Federal % 20 Facility% 80 2 40 60 3 60 40 4 80 20 5 100 00 *For LTCH cost reporting periods beginning on or after 10/01/2015 enter the appropriate code for the blend year representing 50% site neutral payment and 50 % standard payment.* ***6 –Blend Year 1*** *(represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015 through 09/30/16)* ***7 - Blend Years 2 through 4*** *(represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018 or FY 2019* ***8 - Blank –*** *Transition Blend no longer applies with cost reporting periods*

Data Element	File Position	Format	Title	Description
				beginning in on or after 10/01/2019. Full Site Neutral payment **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 — Federal % 25 — Facility% 75 2 — Federal % 50 — Facility% 50 3 — Federal % 75 — Facility% 25 4 — Federal % 100 — Facility% 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end

Data Element	File Position	Format	Title	Description
				of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

Data Element	File Position	Format	Title	Description
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete for hospitals as of FY92. Effective 1/1/2018, this field is used for HHAs only. Enter the HH VBP adjustment factor provided by CMS for each HHA. If no factor is provided, enter 1.00000.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified D = Dual reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank)

Data Element	File Position	Format	Title	Description
				(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, DSH adjustments*, or Allogeneic Stem Cell Acquisition.* Zero-fill if this does not apply.
43	185	X(1)	Capital PPS	Enter the code to indicate the type of

Data Element	File Position	Format	Title	Description
			Payment Code	capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A"08" is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute

Data Element	File Position	Format	Title	Description
				hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter "Y" if participating in Hospital Value Based Purchasing. Enter "N" if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-258	9V9(6)	LV Adjustment Factor	Enter the low-volume hospital payment adjustment factor calculated *in accordance with the low-volume hospital payment regulations at § 412.101.*
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-268	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).

Data Element	File Position	Format	Title	Description
62	269-269	X(1)	LTCH DPP Indicator	Enter a 'Y' if the LTCH is subject to the DPP payment adjustment. Leave blank if the LTCH is not subject to the DPP payment adjustment.
63	270-275	9(2) V9(4)	Supplemental Wage Index	Enter the supplemental wage index that certain providers may be assigned. Enter zeroes if it does not apply.
64	276-276	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag that certain providers may be assigned: 1=Prior Year Wage Index 2=*Special IPPS-comparable Wage Index** 3=Future use Enter blank if it does not apply **Only for LTCH providers. Pricer will override the otherwise determined IPPS-comparable wage index with this value.*
65	*277-285*	*9(7)V99*	*Pass Through Amount for Allogeneic Stem Cell Acquisition*	*Enter the per diem amount based on the interim payments to the hospital. Include acquisition amounts for allogeneic stem cell transplants. Zero-fill if this does not apply.*
65	*286-310*	*X(25)*	*Filler*	