CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12612	**Date: May 2, 2024**
	Change Request 13579

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 25, 2024. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Updates in the Fiscal Intermediary Shared System (FISS) Inpatient Psychiatric Facilities (IPF) Provider Specific File (PSF), Inpatient Rehabilitation Facilities (IRF) PSF, and Outpatient Provider Specific Files (OPSF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement changes to the provider-specific files to support transition policies for the rural adjustments in the IPF PPS, IRF PPS, and ESRD PPS.

EFFECTIVE DATE: October 1, 2024 - PSF updates for IPFs and IRFs; January 1, 2025 - OPSF updates for ESRD facilities
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2024 - PSF updates for IPFs and IRFs; January 6, 2025 - OPSF updates for ESRD facilities

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	4/50.1 - Outpatient Provider Specific File

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: 12612	Date: May 2, 2024	Change Request: 13579

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement changes to the provider-specific files to support transition policies for the rural adjustments in the IPF PPS, IRF PPS, and ESRD PPS.

II. GENERAL INFORMATION

A. Background: As a result of proposed changes to the wage index policy, we are adding one additional valid value for the existing field "Supplemental Wage Index Flag" in the IPF PSF, IRF PSF, and OPSF to ensure each payment system's Pricer pays these providers correctly based on values inputted in the PSF. Additional instructions for MACs when to input the new field will be provided in the annual recurring IPF PPS, IRF PPS, and ESRD PPS change requests.

B. Policy: We are proposing the following changes for IPF PPS and IRF PPS in FY 2025 and to the ESRD PPS in CY 2025:

• Change the wage index CBSA delineations according to the Office of Management and Budget (OMB) Bulletin 23-01.
• Provide a transition of the facility-level rural adjustment in each payment system for providers located in counties that would switch from rural to urban due to the adoption of the CBSA delineations from OMB Bulletin 23-01.

To facilitate the implementation of the rural transition policy, we are adding one (1) additional valid value for the Supplemental Wage Index Flag field in the IPF PSF, IRF PSF, and OPSF to ensure each payment system's Pricer pays providers correctly based on values inputted in the PSF. Additional instructions for Medicare Administrative Contractors (MACs) when to input the new Supplemental Wage Index Flag value will be provided in the annual recurring IPF PPS, IRF PPS, and ESRD PPS change requests.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13579.1	**IPF PPS and IRF PPS Business Requirements** Contractors shall update the valid values for the Supplemental Wage Index Flag field in the PSF. Valid Values **1**=prior year wage index **2**=current year IPPS-comparable wage index (LTCHs only)* **3**=prior year wage index and rural transition applies (IPF and IRF only) **4**=future use Enter blank if it does not apply ***Note:*** *For LTCHs a value of '2' is the current year IPPS-comparable wage index value that is used for short-stay outlier and site neutral payment rate payments. This CR only requires documentation updates for FISS.*					X				IDR
13579.2	Contractors shall continue to send "Supplemental Wage Index" and "Supplemental Wage Index Flag" field information from the PSF to the IPF and IRF PRICERs.									IPF Pricer, IRF Pricer
13579.3	**ESRD PPS Requirements** Contractors shall update the valid values for the Supplemental Wage Index Flag field in the PSF. Valid Values **1**=prior year wage index **2**=prior year wage index and rural transition applies					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	(ESRD Facilities only) **3**=future use Enter blank if it does not apply. ***Note**: This CR only requires documentation updates for FISS.*									
13579.4	Contractors shall continue to send "Supplemental Wage Index" and "Supplemental Wage Index Flag" field information from the OPSF to the ESRD PRICER.									ESRD Pricer

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. 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

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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(Rev. 12612, Issued: 05-02-24)

50.1 - Outpatient Provider Specific File

(Rev. 12612, Issued: 05-02-24; Effective: 01-01-2025; Implementation: 01-06-25)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

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

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.

25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).
49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Contractor #.

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 Reserved 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 24 Rural Emergency Hospitals 25 Indian Health Service Rural Emergency Hospitals 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Free-standing Opioid Treatment Program 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
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank) (blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.

63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	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. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs

74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.
75	X(1)	Filler	Blank.

76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 0000189999, 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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	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 equals a “1” or “2.”
96	X(1)	Special Payment Indicator	The following codes indicate 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

97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children's Hospitals	Children's Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.
106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.
118-122	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 0000189999, 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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA

			if this field is left blank. Does not apply to ESRD Facilities.
123-128	9V9(5)	Payment Model Adjustment (PMA)	Derived from payment model Technical Direction Letter.
129-133	9V9999	Medicare Performance Adjustment (MPA)	Enter the MPA percentage calculated and published by the Centers for Medicare & Medicaid Services (CMS).
134-139	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.
140-140	X(1)	Supplemental Wage Index Flag	Enter the supplemental wage index flag: 1=Prior Year Wage Index 2=Prior Year Wage Index and rural transition applies (ESRD Facilities only) 3=Future use Enter blank if it does not apply.
141-162	X(22)	FILLER	

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

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

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(Rev. 12612; Issued: 05-02-24)

Addendum A - Provider Specific File

(Rev. 12612, Issued: 05-02-24; Effective: 01-01-2025; Implementation: 01-06-25)

Data Element	File Position	Format	Title	Description
1	1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character NPI number.

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td></td><td>11-16</td><td>X(6)</td><td>Provider CMS Certification Number (CCN)</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 provider CMS Certification Number (CCN) 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>
</table>

3	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Year: Greater than 82, but not greater than current year. Month: 01-12 Day: 01-31

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

Data Element	File Position	Format	Title	Description

(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 (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

Data Element	File Position	Format	Title	Description

				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 provider CMS Certification Number (CCN) (See field #2 for a special unit-toprovider 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 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

Data	File	Format	Title	Description

Element	Position			
				_ _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.
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.
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.

Data Element	File Position	Format	Title	Description

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 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

Data Element	File Position	Format	Title	Description

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:

	Federal %	Facility%
1	20	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 beginning in on or after 10/01/2019. Full Site Neutral payment

Data Element	File Position	Format	Title	Description

				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. Federal % Facility% 1 25 75 2 50 50 3 75 25 4 100 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 nonexcluded 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 Medicaredependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that

Data Element	File Position	Format	Title	Description
				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 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.

Data Element	File Position	Format	Title	Description

26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and 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

Data Element	File Position	Format	Title	Description

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) (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

Data Element	File Position	Format	Title	Description
				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.). Zerofill 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.) Zerofill 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. Include pass through amount for Domestic N95 Respirator Procurement. 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. Zerofill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless:

Data Element	File Position	Format	Title	Description

				• 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 CapitalHold 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-toCharge 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-tocharge 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-tocharge 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

Data Element	File Position	Format	Title	Description

				equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute 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 (UCP) amount or enter the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, calculated and published by CMS for each hospital. Effective 10/1/2022, the estimated per discharge supplemental

Data Element	File Position	Format	Title	Description

				payment is for eligible Indian Health Service/Tribal hospitals and hospitals located in Puerto Rico.
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).
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= prior year wage index and rural transition applies (IPF and IRF only) 4=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.

Data Element	File Position	Format	Title	Description

66	286-291	9(4)V9(2)	Pass Through Amount for Direct Medical Education (Medicare Advantage (MA) Exclusion)	Per diem amount of direct graduate medical education to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
67	292-297	9(4)V9(2)	Pass Through Amount for Kidney Acquisition (MA Exclusion)	Per diem amount of kidney acquisition costs to be excluded from MA capitation rates per regulation. Zero-fill if this does not apply.
68	298-306	9(7)V99	Pass Through Amount for Domestic N95 Respirator Procurement	Enter the per diem amount based on the interim payments to the hospital. Include payment adjustments for the additional cost for procurement of wholly domestically made NIOSH-approved surgical N95 respirators.
69	307-310	X(4)	Filler	