CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2933	**Date: April 17, 2014**
	Change Request 8546

Transmittal 2870, dated February 5, 2014, is being rescinded and replaced by Transmittal 2933, dated April 17, 2014, to add a business requirement (BR) to install the IPPS PRICER and cross reference it to R31437, correct BR 10 to remove the uncompensated care payment amount field and add supporting documentation for this BR. All other information remains the same.

SUBJECT: Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Addition of New Fields and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output

I. SUMMARY OF CHANGES: The inpatient PSF will be expanded to include 3 new fields and an expansion of the existing Model 1 discount percentage field as follows:

1. Add an indicator for hospitals subject to the Hospital Acquired Conditions (HAC) reduction program for future implementation

2. Add an estimated interim per claim Uncompensated Care Payment amount

3. Add an indicator for hospitals subject to an Electronic Health Records Incentive Program reduction for future implementation

4. Expand the existing 2-byte Model 1 discount percentage field to 3-bytes

For clarity, four established payment amount fields will be renamed and 4 new payment amount fields will be added to the IPPS PRICER output record for future use.

EFFECTIVE DATE: July 1, 2014
IMPLEMENTATION DATE: July 7, 2014

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

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2933	Date: April 17, 2014	Change Request: 8546

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SUBJECT: Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Addition of New Fields and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output

EFFECTIVE DATE: July 1, 2014
IMPLEMENTATION DATE: July 7, 2014

I. GENERAL INFORMATION

A. Background: Section 3008 of the Affordable Care Act (ACA) establishes a program, beginning in FY 2015, for Inpatient Prospective Payment System (IPPS) hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain Hospital Acquired Conditions (HACs). HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

Section 3133 of the ACA provides for an additional payment for a hospital's uncompensated care. Each Medicare disproportionate-share (DSH) hospital will receive an uncompensated care payment (UCP) based on its share of uncompensated are as calculated by CMS for Medicare DSH hospitals. Currently, for FY 2014, the estimated per claim UCP amount is stored in PRICER. In order to make changes to the amounts more efficient, we are adding the estimated per claim UCP amount to the PSF.

The Medicare Electronic Health Record (EHR) Incentive Program provides incentive payments for eligible acute-care inpatient hospitals that are meaningful users of certified EHR technology. Eligible-acute care inpatient hospitals are defined as "subsection (d) hospitals"—which are generally hospitals that are paid under the IPPS and are located in one of the 50 states or the District of Columbia. Hospitals that are not meaningful users of certified EHR technology will be subject to payment adjustments beginning in FY 2015.

Model 1 of the Bundled Payments for Care Improvement (BPCI) initiative provides a discounted payment to Model 1 participating hospitals for the acute-care hospital stay. The discount will be phased in over the performance period of 3 years. To accommodate the 0.5% discount for months 7 to 12, the Model 1 discount percentage field in the PSF must be expanded.

For clarity, four established payment amount fields will be renamed. In addition, we are redefining existing filler in the output record PRICER returns to Fiscal Intermediary Standard System (FISS) to accomodate future policy and/or legislative changes that might require system changes.

B. Policy: In order to prepare for the HAC Reduction Program and the Electronic Health Records Incentive Program, Medicare is expanding the IPPS PSF to include new fields to identify hospitals subject to these reductions. In addition, to have more efficient control over possible changes to the estimated uncompensated care amount, we are expanding the PSF to include this amount. Additional payment amount fields will be added to the IPPS PRICER output record for future use in implementing potiential policy and

or statutory changes. Finally, we will correct the Model 1 discount percentage field from 2-bytes to 3-bytes.

Note: This CR is not implementing the HAC Reduction Program initiative or the Electronic Health Records Incentive Program, but is only preparing our systems for the future. Specific instructions implementing these programs including manual updates to Addendum A of the Internet Only Manual (IOM), will be issued to contractors in the future in the event these policies are finalized.

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	
8546.1	The CMS inpatient PSF record shall be expanded to include: • A new 1-byte field to carry the HAC Reduction Program Indicator in data element 56, file position 241, format X • A new 9-byte numeric field to carry the estimated per claim uncompensated care payment amount in data element 57, file position 242-250, format 9(7)V99. • A new 1-byte field to carry the EHR Program Reduction Indicator in data element 58, file position 251, format X • Expand data element 55 to carry 3-bytes, file position 238-240 • Shift the filler down **NOTE:** Attachment A provides what will be the new PSF record layout used by the IPPS Pricer.									CMS
8546.2	The IPPS Pricer input and output records shall be expanded to include the: • 1-byte HAC Reduction Program Indicator upon official implementation of the HAC Reduction program effective 10/1/14 • 9-byte uncompensated care payment amount for FY 2015 **Note:** MACs will receive a list of hospitals and per claim uncompensated care payment amounts in the FY2015 IPPS Recurring CR									IPPS Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 1-byte EHR Program Reduction Indicator for future implementation • 3-byte Model 1 BPCI Discount percentage									
8546.3	The IPPS Pricer output record shall be expanded to include: • PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02). • PPS-FLX5- PAYMENT PIC S9(07)V9(02). • PPS-FLX6- PAYMENT PIC S9(07)V9(02). • PPS-FLX7- PAYMENT PIC S9(07)V9(02).									IPPS Pricer
8546.4	FISS shall modify its inpatient provider specific file record to include the following fields to allow contractors to input when CMS provides it to them: • 'Y' or 'N' in the 1-byte HAC Reduction Indicator field • 'Y' or no value (blank) in the EHR Incentive Program Reduction Indicator field • The estimated per discharge Uncompensated Care Payment amount provided by CMS in the 9-byte field, 9(7)V99 • 3-byte Model 1 BPCI Discount percentage					X				
8546.4.1	FISS shall populate a value of 'N' in the HAC Reduction Indicator field in the PSF for IPPS providers. NOTE: When the HAC policy is implemented, MACs will receive instructions for updating the PSF with a 'Y' for those providers subject to the HAC reduction.					X				
8546.5	FISS shall modify the PRICER input record and pass the data listed in BR 8546.3 into the PRICER.					X				
8546.6	FISS shall modify its system to accept the 1-byte					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	HAC Program Reduction Indicator field, the 1-byte EHR Program Reduction Indicator field, the 9-byte estimated per discharge Uncompensated Care Payment amount and the expanded Model 1 BPCI % field from the IPPS Pricer's output record									
8546.7	FISS shall ensure that the inpatient PSF record sent to CMS on a quarterly basis includes the fields listed in BR 8546.4. This includes updating reports 710, 964 and 967.					X				
8546.8	FISS shall ensure that the new fields and the expanded BPCI Model 1% field flow to the PS&R.					X				Cost Report, PS&R
8546.9	CWF, FPS, IDR, NCH and MedPar shall make modifications to accept the new and expanded fields.								X	FPS, IDR, MedPar, NCH
8546.10	Medicare Contractors shall modify their transmit records to accommodate the new and expanded fields listed below to allow them to flow to downstream systems: • 1-byte HAC Reduction Program Indicator upon official implementation of the HAC Reduction program effective 10/1/14 • 1-byte EHR Program Reduction Indicator for future implementation • 3-byte Model 1 BPCI Discount percentage • PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02) • PPS-FLX5- PAYMENT PIC S9(07)V9(02) • PPS-FLX6- PAYMENT PIC S9(07)V9(02) • PPS-FLX7- PAYMENT PIC S9(07)V9(02)					X			X	
8546.11	FISS shall update the DRG Cost Disclosure Inquiry Screens and Reports (630 and 630A for both contractor and provider viewing with any necessary expansion for the new and expanded fields listed in BR 8546.3.					X				
8546.12	The 4 established payment amount fields shall be									IPPS Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	renamed in the IPPS PRICER output record as follows: • From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT • From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT • From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT • From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT									
8546.13	Medicare contractors shall rename the 4 established payment amount fields as follows: • From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT • From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT • From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT • From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT					X			X	Cost Report, FPS, IDR, MedPar, NCH, PS&R
8546.14	Medicare Contractor shall modify its system to accept the following fields from the IPPS Pricer output record. • PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02). • PPS-FLX5- PAYMENT PIC S9(07)V9(02). • PPS-FLX6- PAYMENT PIC S9(07)V9(02). • PPS-FLX7- PAYMENT PIC S9(07)V9(02).					X				
8546.15	Medicare Contractor shall modify its system to accept the following fields from the FISS records • PPS- EHR-PAYMENT-ADJUST-AMT PIC									Cost Report, IDR, PS&R

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	S9(07)V9(02). • 2. PPS-FLX5- PAYMENT PIC S9(07)V9(02). • 3. PPS-FLX6- PAYMENT PIC S9(07)V9(02). • 4. PPS-FLX7- PAYMENT PIC S9(07)V9(02).									
8546.16	Medicare Contractor shall modify its system to accept the following fields from the CWF records. • PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02). • PPS-FLX5- PAYMENT PIC S9(07)V9(02). • PPS-FLX6- PAYMENT PIC S9(07)V9(02). • PPS-FLX7- PAYMENT PIC S9(07)V9(02).									FPS, MedPar, NCH
8546.17	FISS shall install IPPS Pricer version 2014.5**.**					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8546.18	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article.	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
8546.3	Implementation instructions for the Medicare EHR Program Payment Adjustment for Subsection d and Waiver Hospitals under the Fiscal Intermediary Shared System (FISS) will be provided in a separate CR.
8546.10	The uncompensated care payment amount field (not listed in this BR) is already flowing to downstream systems.
8546.17	The IPPS recurring hours associated with R31437 shall be utilized for this CR.

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, 410-786-5888 or Cami.DiGiacomo@cms.hhs.gov , Sarah Shirey-Losso, 410-786-0187 or Sarah.Shirey-Losso@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

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 do 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.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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(Rev.2933, Issued: 04-17-14)

Addendum A - Provider Specific File

(Rev. 2933, Issued 04-17-14, Effective 07-01-14, Implementation 07-07-14)

<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>
</table>

Data Element	File Position	Format	Title	Description
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
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

Data Element	File Position	Format	Title	Description
				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 (during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 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). Eff. 10/1/12, this provider type no longer valid. 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

Data Element	File Position	Format	Title	Description
				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 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.

Data Element	File Position	Format	Title	Description
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. 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
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made

Data Element	File Position	Format	Title	Description
				on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 — Federal % 20 — Facility% 80 2 — Federal % 40 — Facility% 60 3 — Federal % 60 — Facility% 40 4 — Federal % 80 — Facility% 20 5 — Federal % 100 — Facility% 00 **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.

Data Element	File Position	Format	Title	Description
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 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 as of FY92.
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
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

Data Element	File Position	Format	Title	Description
				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)	Standardized Amount Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank)(blank)(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 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

Data Element	File Position	Format	Title	Description
				conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill 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: • 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	This is for IPPS hospitals and IRFs only.

Data Element	File Position	Format	Title	Description
			Medical Education Ratio	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 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	*252-260*	*X(9)*	*Filler*	