CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4157	**Date: November 2, 2018**
	Change Request 10962

SUBJECT: Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions and Shared Systems Changes

I. SUMMARY OF CHANGES: This Change Request clarifies policies related to hospitals and Critical Access Hospitals (CAHs) with respect to services furnished to swing-bed patients, as well as policies related to pass-through reimbursement for certified registered nurse anesthetist (CRNA) services.

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

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	3/60/Swing-Bed Services
R	3/100/100.2/Payment for CRNA or AA Services
R	3/Addendum A - Provider Specific File
R	4/250/250.3.3.1/Payment for CRNA Pass-Through Services
R	4/250/250.3.3.2/Payment for CRNA Services (Method II CAH only)
R	6/10/10.2/Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

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: 4157	Date: November 2, 2018	Change Request: 10962

SUBJECT: Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions and Shared Systems Changes

EFFECTIVE DATE: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: Critical Access Hospital (CAH) swing-bed services are not subject to the skilled nursing facility (SNF) prospective payment system. Instead, CAHs are paid based on 101 percent of reasonable cost for swing-bed services. As is the case with CAH inpatient services, CAH swing-bed services are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and in the regulations at 42 CFR § 411.15(m). Therefore, because CAH swing-bed services are subject to the hospital bundling requirements, CMS is clarifying that nonprofessional services provided to a CAH swing-bed patient must be included on the CAH's swing-bed bill.

In addition, certified registered nurse anesthetist (CRNA) pass-through payments (see 42 CFR § 412.113 (c)) provide qualifying hospitals and CAHs with reasonable cost-based payments for CRNA services. CMS is clarifying that qualifying hospitals and CAHs are eligible to receive pass-through payments for CRNA services provided to hospital and CAH swing-bed patients since these patients are inpatients for this purpose. CRNA pass-through services provided to swing-bed patients must be included on the hospital's or CAH's swing-bed bill.

CMS is also revising manual language related to CRNA pass-through payments to clarify existing policy.

B. Policy: The intention of this CR is to update policy manual, Pub. 100-04, Medicare Claims Processing Manual. In the 2001 "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities-Update; Final Rule" 66 Fed. Reg. 39593 (July 31, 2001), CMS clarified that swing-bed hospitals (this also includes CAHs) are subject to hospital bundling (see section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m)).

Additionally, pass-through payments may be made for CRNA services furnished to inpatients of a hospital or CAH that qualify for such payments. (Note: Per 69 Fed. Reg. 49096 (Aug. 11, 2004), a swing-bed is a bed that is available for use to provide acute inpatient care or SNF-level care.) Furthermore, the regulations (see 42 CFR § 412.113 (c)(2)(i)(D)) state that under the pass-through provision, a CRNA must agree in writing not to bill Medicare for his or her patient care to Medicare beneficiaries. Accordingly, provided a hospital or CAH has satisfied the requirements for CRNA pass-through payments at 42 CFR § 412.113(c), the fact that a beneficiary is receiving services in a swing-bed in the hospital or CAH should not preclude the hospital or CAH from receiving pass-through payments for CRNA services furnished to that patient.

II. 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	
10962.1	The Medicare contractor shall allow Critical Access Hospitals (CAHs) to bill for: (1) bed and board; (2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements; which are rendered in a CAH swing-bed on the following: Type of bill (TOB): 18x Provider number range beginning with: Z300 through Z399	X								
10962.2	The Medicare contractor shall allow for services rendered by a certified registered nurse anesthetist (CRNA) in a CAH swing-bed, where the CAH has CRNA pass-through: TOB: 18x Revenue code (REV): 0964 professional service And REV: 037x (technical) CAHs with a CRNA pass-through Provider number range beginning with: Z300 through Z399	X				X				
10962.3	The Medicare contractor shall allow for services rendered by a CRNA in a hospital swing-bed, where the short term acute care hospital has CRNA pass-through: TOB: 18x REV: 0964 professional service And REV: 037x (technical)	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Hospitals with a CRNA pass-through Provider numbers range beginning with: U001 through U879									
10962.4	The Medicare contractor shall include instructions on how to update the FISS provider file in order to allow the CAH swing-bed claim to be reimbursed for CRNA pass-through services.	X				X				
10962.5	The Medicare contractor shall bypass any reason code that prevents CAH swing-beds from submitting eligible CRNA services that have a pass-through: TOB 18x (CAH swing-bed) REV code: 0964 (which has CRNA pass-through) Provider numbers: Z300 through Z399 FISS shall bypass any reason codes as identified					X				
10962.6	The Medicare contractor shall make all necessary updates to the financial system in order to allow CAH and hospital swing-beds to receive CRNA pass-through payments. This includes, but is not limited to, online screen entry, remittance advice, and financial reports.	X				X				
10962.7	The Medicare contractor shall use the current 810 interface and the following coding for paying CRNA pass-through for hospital swing-beds: AL = Periodic Interim Payment (PIP) non Phy Anest PT AM = Non-PIP non Phy Anest PT The Medicare contractor shall also use the current PLB codes AL and AM.					X				
10962.8	HIGLAS shall accept and process the 810 interface record for CRNA pass-through from hospital swing-beds.									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10962.9	The Medicare contractor shall refer to updated cost report guidance included in Provider Reimbursement Manual, Part 2 (CMS Pub. 15-2), chapter 40.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10962.10	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

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): Joe Brooks, 410-786-0275 or joseph.brooks@cms.hhs.gov , Renate Dombrowski, 410-786-4645 or renate-rockwell.dombrowski@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

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

60 - Swing-Bed Services
(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Swing-bed services must be billed separately from inpatient hospital services. Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI. NOTE: The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.):

"U" = short-term/acute care hospital swing-bed;
"W" = long-term hospital swing-bed;
"Y" = rehabilitation hospital swing-bed; and
"Z"=CAH swing-bed.

Note that CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)). Certified registered nurse anesthetist services paid on a pass-through basis are also to be included on the CAH swing-bed bill.

A. - Inpatient Hospital Services in a Swing-Bed

The patient status code of 03 is inserted on the claim when the beneficiary swings from acute to SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The A/B MAC (A) indicates in the Statement Covers Through Date the last day of care at the hospital level.

If the beneficiary is discharged from a Medicare swing-bed and remains in the hospital, there is no need for a no-pay bill. However, if a beneficiary continues to receive care after completing their stay in a SNF swing-bed, in a NF swing-bed, the hospital must submit covered claims to Medicare.

B. - SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;

  - State level agreements may call for varying types of bill coding Type of Bill. The CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the A/B MAC (A) accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, i.e., 18X or 21X. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown.

100.2 - Payment for CRNA or AA Services
(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

This section discusses reasonable cost-based payment for CRNA services *(42 CFR § 412.113(c))*. Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Anesthesia services furnished on or after January 1, 1989, and before January 1, 1990, at a rural hospital or CAH by a qualified hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The A/B MAC (A) determines the hospital's qualification using the following criteria:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.
- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- The hospital or CAH must demonstrate that during the 1987 calendar year, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH must agree in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

*In addition to the criteria described above, t*o maintain eligibility for reasonable cost-based payment for services furnished on or after January 1, 1990, a hospital or CAH must *provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures requiring anesthesia services did not exceed 800 procedures.*

If a hospital or CAH did not qualify for reasonable cost-based payment for CRNA or AA services in calendar year 1989, it can qualify in subsequent years if it demonstrates to the Medicare Contractor prior to the start of the calendar year that it met the*se* criteria noted below:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.
- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.
- *T*he hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, *the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services* did not exceed 800 procedures.

Effective for calendar years beginning January 1, 1991, the A/B MAC (A) determines the number of surgical procedures for the immediately preceding year by summing the number of surgical procedures for the 9-month period ending September 30, annualized for a 12-month period.

Effective December 2, 2010, in addition to a hospital or CAH that is located in a rural area (as defined for PPS purposes), a hospital or CAH may be eligible to be paid based on reasonable cost for CRNA or AA services, if the hospital or CAH has reclassified as rural under 42 Code of Federal Regulations 412.103.

To prevent duplicate payments, the A/B MAC (A) informs A/B MACs (B) of the names of CRNAs or AAs, the hospitals and/or CAHs with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished after the hospital's and/or CAH's election of reasonable cost payments, the A/B MAC (B) must recover the overpayment from the CRNA or AA.

Since a swing-bed is a bed that is available for use to provide acute inpatient care or SNF-level care and the CRNA/AA pass-through provision applies to hospital inpatients, CRNA and AA services provided to hospital and CAH swing-bed patients under the pass-through provision must be included on the hospital or CAH swing-bed bill.

Addendum A - Provider Specific File

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

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>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). 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 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).

Data Element	File Position	Format	Title	Description
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.
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.

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). Effective the start of the hospital's FY 2018 cost reporting period through the start of the hospital's cost reporting period beginning on or after October 1, 2019 (FY 2020), code a 'S' for an LTCH that meets the provisions of section 15009 of 21st Century Cures Act.
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made 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 and before 10/01/2015. Federal % Facility% 1 20 80

Data Element	File Position	Format	Title	Description
				2 40 60 3 60 40 4 80 20 5 100 00 **LTCH PPS:** Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015. 6 – Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY16 (on or after 10/01/2015 through 09/30/16) 7 - Blend Year 2 through 4 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning in FY17, FY18 or FY19 8 – Transition Blend no longer applies with cost reporting periods beginning in FY20 (on or after 10/01/2019) **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 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.

Data Element	File Position	Format	Title	Description
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 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.)

Data Element	File Position	Format	Title	Description
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.
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.

Data Element	File Position	Format	Title	Description
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) (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

Data Element	File Position	Format	Title	Description
				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 qualify for CRNA pass-through reimbursement*, 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, 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.

Data Element	File Position	Format	Title	Description
				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 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

Data Element	File Position	Format	Title	Description
				"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 and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital.
60	259-263	9(5)	County Code	Enter the County Code. Must be 5 numbers.
61	264-310	X(47)	Filler	

250.3.3.1 - Payment for CRNA Pass-Through Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

CAHs are eligible to receive CRNA pass-through payments ("pass-through exemption") for both inpatient and outpatient services if they meet criteria discussed at 42 CFR § 412.113(c) of the regulations. CRNA pass-through payments and the Method II election for outpatient CAH services are applied as described below. Note that for CAHs that have a CRNA pass-through exemption, all CRNA services provided to CAH swing-bed patients must be included on the CAH swing-bed bill. (See MCPM, Ch. 3, 60 and 100.2 for more information)

If a CAH meets the criteria for a pass-through exemption *and* is interested in selecting Method II *for its physicians and/or other practitioners*, it can choose *Method II* for all outpatient professionals except the CRNA, and still retain the approved CRNA *pass-through* exemption for both inpatient and outpatient *CRNA* professional services.

Alternatively, *a* CAH, with an approved *pass-through* exemption, can choose to give up its *pass-through* exemption for both inpatient and outpatient *CRNA* professional services in order to include its CRNA outpatient professional services under Method II. By choosing to include the CRNA under Method II for outpatient services, *the CAH* loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the A/B MAC (B) for the CRNA inpatient professional services. All A/B MAC (A) payments for CRNA services are subject to cost settlement.

Provider Billing Requirements for *CRNA Pass-Through*

TOBs = 85X and 11X *and 18X*

Revenue Code 037X for CRNA technical services

Revenue Code 0964 for Professional services

Anesthesia HCPCS codes and for any HCPCS codes for services the CRNA is legally authorized to perform in the state in which the services are furnished

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement *(101 percent of reasonable cost)*

Revenue Code 0964, CRNA professional service = Cost Reimbursement *(100 percent of reasonable cost)* for both inpatient *(including swing-bed)* and outpatient

Deductible and coinsurance apply.

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

250.3.3.2 - Payment for CRNA *Services* (Method II CAH only)

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Provider Billing Requirements for Method II CRNA - Gave up Pass-Through Exemption (or never had exemption)

TOB = 85X

Revenue Code = 037X for CRNA technical service

Revenue Code = 0964 for CRNA professional service

HCPCS Code for services the CRNA is legally authorized to perform in the state in which the services are furnished

Reimbursement - For dates of service on or after July 1, 2007

Revenue Code 037X for CRNA technical service = Cost Reimbursement *(101 percent of reasonable cost)*

Revenue Code 0964 for CRNA professional service = Based on 100 percent of the allowed amount when not medically directed or 50 percent of the allowed amount when medically directed.

Providers bill a "QZ" modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service on or after July 1, 2007

Identify anesthesia claims by HCPCS code range from 00100 through 01999
Non-medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor minus (deductible and coinsurance) times 1.15

Medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor times medically directed reduction (50 %) minus (deductible and coinsurance) times 1.15

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Reimbursement - For dates of service prior to July 1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = 115% times 80% (not medically directed) or 115% times 50% (medically directed) of allowed amount (Use Anesthesia formula) for outpatient CRNA professional services.

Providers a "QZ" modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service prior to July 1, 2007

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge when not medically directed. Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum of base units and time

Sum of base units and time times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB04) Base Units = Anesthesia HCPCS

Conversion Factor = File - MU00.@BF12390.MPFS.CYXX.ANES.V1023

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Consolidated billing applies to:

- Participating SNFs;
- Short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing-bed hospitals.

But does not apply to:

- A nursing home that is not Medicare-certified, such as:
    - A nursing home that does not participate at all in either the Medicare or Medicaid programs;
    - A non-certified part of a nursing home that also includes a participating distinct part SNF unit; and
    - A nursing home that exclusively participates in the Medicaid program as an NF.
- *Critical Access Hospitals (CAHs) certified as swing-bed hospitals. CAH swing-bed services are subject to the hospital bundling requirement at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m).*

Medicare Coordinated Care Demonstration

Services for beneficiaries covered under the Medicare Coordinated Care Demonstration will not be subject to consolidated billing. Common Working File (CWF) will appropriately edit for these codes so that the A/B MACs (B) will pay them separately.