CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4236	**Date: February 8, 2019**
	Change Request 11083

SUBJECT: Update to Publication (Pub.) 100-04 Chapter 3 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-04, chapter 3. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: March 12, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 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	3/20.1.2.7/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/20.2.1.1.2/Procedures for Paying Claims Without Passing through the MCE
R	3/50/Adjustment Bills
R	3/50.2/Claim Change Reasons
R	3/50.3/Late Charges
R	3/90.1.1/The Standard Kidney Acquisition Charge
R	3/90.1.3/Billing for Donor Post-Kidney Transplant Complication Services
R	3/100.4/Billing for Services After Termination of Provider Agreement
R	3/140.2.5.3/Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)
R	3/140.2.10/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs
R	3/150.28/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/170.1.3/Completion of the Notice of Election for RNHCI
R	3/170.2.2/Required Data Elements on Claims for RNHCI Services
R	3/190.7.2.5/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/200.2/Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

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: 4236	Date: February 8, 2019	Change Request: 11083

SUBJECT: Update to Publication (Pub.) 100-04 Chapter 3 to Provide Language-Only Changes for the New Medicare Card Project

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub 100-04, chapter 3.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

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	
11083.1	Medicare Administrative Contractors (MACs) shall be aware of the updated language for the New Medicare Card Project in Pub. 100-04, chapter 3.	X		X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@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

20.1.2.7 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.

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

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital's outlier claims are to be reconciled.

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

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

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

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

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

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

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

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

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

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

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

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating

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

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

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.

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

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Revised Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Difference between these amounts
Original Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Revised Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Revised Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)

List of Data Elements for FISS Extract
Difference between these amounts
Original Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Revised Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
TOT CHRG – total billed charges (claim page 3)
COV CHRG – total covered charges (claim page 3)
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)

List of Data Elements for FISS Extract
Original UNCOMP CARE AMT (claim page 40)
Revised UNCOMP CARE AMT (claim page 40)
Difference between these amounts
Original VAL PURC ADJ AMT (claim page 40)
Revised VAL PURC ADJ AMT (claim page 40)
Difference between these amounts
Original READMIS ADJ AMT (claim page 40)
Revised READMIS ADJ AMT (claim page 40)
Difference between these amounts
Original HAC PAYMENT AMT (claim page 40)
Revised HAC PAYMENT AMT (claim page 40)
Difference between these amounts
Original EHR PAY ADJ AMT (claim page 40)
Revised EHR PAY ADJ AMT (claim page 40)
Difference between these amounts
Original PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Revised PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Before an inpatient claim may be paid without first going through the MCE, the contractor shall obtain approval from CMS Central Office or the RO.

Note: In certain situations, contractors bypass the MCE through an established, CMS-instructed claim processing procedure (e.g., to verify a facility is certified to perform a specified service after a MCE limited coverage edit is applied). Such scenarios do not require approval from the RO as the approval for such a bypass was inherently implied when the established procedure was first implemented.

In all instances involving payment outside the normal inpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the MCE using the appropriate field in FISS.
- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.
- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor MCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a report of all inpatient claims paid without processing through the MCE with the exception of override situations explained in the Note above (e.g., for limited coverage edits). The list of claims paid outside of the MCE is to include the following information:

    - *Medicare beneficiary identifier*
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.

50 - Adjustment Bills

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 9)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of A/B MAC (A)'s medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be initiated as a result of OIG and MSP requests. The A/B MAC (A) will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill for Payer A, B, or C.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the A/B MAC (A) pays on the basis of the log. This log must include:

- Patient name;

- *Medicare beneficiary identifier*;

- Dates of admission and discharge, or from and thru dates;

- Adjustment in charges (broken out by ancillary or routine service); and

- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the A/B MAC (A) enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

NOTE: Information regarding the claim form locators that correspond with these fields on the Form CMS-1450 is found in chapter 25.

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the A/B MAC (A) initiates), the A/B MAC (A) submits an adjustment bill to CWF following its acceptance of the initial bill. To verify CMS' acceptance, it takes one or both of the following actions:

A. - General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- A/B MAC (A) control number (ICN/DCN);
- Surname;
- *Medicare beneficiary identifier*;

When a definite match cannot be made on the 3 fields above, the provider's A/B MAC (A) will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and
- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect *Medicare beneficiary identifiers*. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its A/B MAC (A) either electronically or on hard copy. Electronic submission is preferred.

The A/B MAC (A) must enter the following bill types that relate to the entity generating the adjustment request:

Bill Type	Description
XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	A/B MAC (A)

Bill Type	Description
XXM	MSP
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the A/B MAC (A) will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the A/B MAC (A) receives a CWF alert or a CMS-L1002.

The A/B MAC (A) prepares an adjustment if instructed by CO or RO to make a change. Typically, the A/B MAC (A) receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the A/B MAC (A) to correct it.

If the A/B MAC (A) furnished the A/B MAC (B) a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the A/B MAC (A) must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the A/B MAC (A) stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the A/B MAC (A) notes this and processes adjustments to subsequent bills if it services the provider.

If the A/B MAC (A) does not service the provider, CMS will contact the A/B MACs (A), which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an A/B MAC (A) of the appropriate adjustment actions.)

B. - Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the A/B MAC (A) payment notice for adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the A/B MAC (A) without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The A/B MAC (A) processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date

through the discharge date. When the adjustment bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, the A/B MAC (A) makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

50.2 - Claim Change Reasons

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. - Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its A/B MAC (A) with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a *Medicare beneficiary identifier* or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change

reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the ASC X12 837 institutional claim format or on the hard copy Form CMS-1450 For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B. - Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The A/B MAC (A) must apply them to each incoming adjustment request.

- If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the A/B MAC (A) rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."

- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the A/B MAC (A) rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."

- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the A/B MAC (A) rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the A/B MAC (A) rejects the request back to the provider with the following message, "only one claim change reason code may apply to a single adjustment request from a provider. Choose the single claim change reason code that best describes the reason for the provider's request and resubmit."

- If the provider submits an adjustment request as type of bill not equal to XX7 or XX8, the A/B MAC (A) rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to XX7 or XX8."

- If the claim change reason code is equal to D0, the A/B MAC (A) compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."

- If the claim change reason code is equal to D1, the A/B MAC (A) compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the A/B MAC (A) rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."

- If the claim change reason code is equal to D2, the A/B MAC (A) compares revenue codes/HCPCS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS must change for claim change reason code D2."

- If the claim change reason code is equal to D3, the A/B MAC (A) compares the ending date on the provider's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Thru dates must change for the claim change reason code D3."

- If the claim change reason code is equal to D4, the A/B MAC (A) compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."

- If the claim change reason code is equal to D5 or D6, type of bill must be equal to XX8 on the provider's request. If type of bill is not equal to XX8, the A/B MAC (A) rejects the request back to the provider with the message, "Type of bill must be equal to XX8 for claim change reason codes D5 or D6."

- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the A/B MAC (A) rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."

- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the A/B MAC (A) rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the A/B MAC (A) rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."

- If the claim change reason code is equal to E0, the A/B MAC (A) compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the A/B MAC (A) rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

If an adjustment the provider initiates results in a change to a higher weighted DRG, the A/B MAC (A) edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the A/B MAC (A) processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the A/B MAC (A) processes the claim for payment and forwards it to CWF.

The A/B MAC (A) must suspend for investigation all adjustment requests with claim change reason codes D4, D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

C. - Additional edits

The A/B MAC (A) must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;

- A change in DRG based on a change in age or sex;

- A change in deductible;

- An adjustment request that changes a previously submitted QIO adjustment request;

- An adjustment of a bill due to a change in utilization or spell data on another bill;

- A reopening to change a no-payment bill to a payment bill;

- A reopening to pay a previously denied line item;

- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or

- An adjustment request with a claim change reason code equal to E0, and the claim is for a PPS provider. The A/B MAC (A) must investigate if the change is from patient status 02, transferred to another acute care facility.

50.3 - Late Charges

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

HO-411.3, HO-IM411.3

Providers billing under Inpatient Hospital PPS, Outpatient PPS, SNF PPS, or HHA PPS may not bill late charges, nor will the contractor accept such bills, for any type of PPS service, inpatient or outpatient. Charges omitted from the original bill must be submitted on an adjustment bill that contains all pertinent charges including those billed earlier. When the provider submits late charges on bills to the A/B MAC (A) as bill type XX5, these bills contain **only** additional charges. Adjustment requests and not late charge bills should be submitted for

- Services on the same day as outpatient surgery subject to the ASC limit,

- ESRD services paid under the composite rate,

- All inpatient accommodation charges, and

- All inpatient PPS ancillaries as adjustment requests.

The provider may submit the following charges omitted from the original paid bill to the A/B MAC (A) as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for HHA services under either Part A or Part B, hospice services, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CHMC services, and ESRD services not included in the composite rate; and

- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS hospitals. The hospital may **not** submit late charges (XX5) for inpatient accommodations. The hospital must submit these as adjustments (bill type XX7).

The A/B MAC (A) has the capability to accept XX5 bill types electronically and process them as initial bills except as described in the following paragraph.

The A/B MAC (A) also performs the following edit routines on any XX5 type bills received:

- Pass all initial bill edits, including duplicate checks.

- Must not be for any of: Inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, “This change requires an XX7 debit-only or XX8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate.”

- When an XX5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, *Medicare beneficiary identifiers* equal, and patient surname equal), the A/B MAC (A) must determine the status of the original paid bill. If it is denied, the A/B MAC (A) must deny the late charge bill.

- If an xx5 does not suspend as a potential duplicate, the A/B MAC (A) rejects it back to the provider with the message, “No original bill paid. Please combine and submit a single original bill (XX1).”

- If the original bill was approved and paid, the A/B MAC (A) compares the revenue codes on the original paid bill with the associated late charge bill:

    - For all providers (any bill type), if any are the same, and are revenue codes 041x, 042x, 043x, 044x, 063x, 076x, or 091x, the A/B MAC (A) or (HHH) rejects the bill back to the provider with the message, “You must submit an adjustment (7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill.”

    - For HHAs (bill type 32X, 33X, or 34X), the A/B MAC (HHH) must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0291, 0293, 055x, 056x, 057x, 058x, 059x, 060x, 066x, the A/B MAC (HHH) rejects the bill back to the provider with the message, “You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

    - For hospital outpatient services (bill type 13X only), the A/B MAC (A) must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0255, 032x, 033x, 034x, 035x, 040x, 062x, 073x, 074x, 092x, or 0943, the A/B MAC (A) rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

    - For RDFs (bill type 72X or 73X), the A/B MAC (A) must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 0634, 0635, 082x, 083x, 084x, 085x, or 088x, the A/B MAC (A) rejects the bill back to the provider with the message, “You must submit an adjustment (XX7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill.”

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the A/B MAC (A) must suspend and investigate the late charge bill.

- The A/B MAC (A) must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any XX5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The A/B MAC (A) may decide to perform additional edits on late charge bills.

90.1.1 - The Standard Kidney Acquisition Charge

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and
- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on revenue code 081X. Kidney acquisition charges are not considered for the IPPS outlier calculation.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

A. - Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B. - Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C. - Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the A/B MAC (A) at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE:

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

D. - Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E. - Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as

all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F. - Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's *Medicare beneficiary identifier*). Modifier Q3 (Live Kidney Donor and Related Services) appears on the claim. For services performed on or after January 1, 2011 CWF shall allow Edit 5211 to be overridden at the contractor level. Also, contractors shall override Edit 5211 when this modifier appears on claims for donor services it receives when the recipient is deceased (See Publication 100-02, Chapter 11, Section 80.4).

NOTE: For institutional claims, contractors may manually override the CWF edit as necessary.

G. - Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.

90.1.3 - Billing for Donor Post-Kidney Transplant Complication Services

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.

All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor's transplant discharge will be billed under the recipient's *Medicare beneficiary identifier* and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.

- All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's *Medicare beneficiary identifier*)

- Modifier Q3 (Live Kidney Donor and Related Services) appears on each covered line of the claim that contains a HCPCS code.

Institutional claims will be required to also include:

- Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)

- Patient Relationship Code 39 (Organ Donor)

Contractors shall override Edit 5211 when modifier Q3 appears on claims for donor services it receives when the recipient is deceased (See Pub. 100-02, chapter 11, section 80.4).

NOTE: For institutional claims which do not require modifiers, contractors may manually override the CWF edit as necessary.

100.4 - Billing for Services After Termination of Provider Agreement

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

HO-404, HH-433

An agreement with a hospital is not time-limited and has no fixed expiration date.

A. - Part A Billing

A hospital whose provider agreement terminates (voluntarily or involuntarily), may be reimbursed for covered Part A inpatient services for up to 30 days for services furnished **on or after the effective date of termination** for beneficiaries who were admitted **prior** to the termination date.

EXAMPLE:

Termination date: 6/30/01

Beneficiary admitted on or before 6/29/01

Payment can be made: 6/30/01, up to and including 7/29/01

B. - Assuring That Hospitals Continue to Bill for Covered Services

Upon cessation of a hospital's participation in the program, it supplies the Regional Office the names and *Medicare beneficiary identifiers* of Medicare beneficiaries entitled to have payment made on their behalf, and continues to bill for covered services in accordance with subsection A. It continues to submit "no-payment" death or discharge bills for Medicare beneficiaries admitted prior to the termination of the provider's agreement.

C. - Part B Billing

Following termination of its agreement, a hospital is considered to be a "nonparticipating hospital." An inpatient of such a hospital who has Part B coverage, but for whom Part A benefits have been exhausted, or are otherwise not available, is entitled to reimbursement for those services that are covered in a nonparticipating institution. Services, if rendered, must be billed on Form CMS-1500 and sent to the A/B MAC (B). If a hospital has been billing on the CMS-1554 for physician services, it continues to do so.

If a terminated hospital meets the necessary criteria, it may be certified to provide emergency services, and will be assigned an emergency provider number (E suffix). This procedure is not automatic, however, and hospitals which are terminated for Life Safety Code violations may never be able to qualify as emergency providers. Should a terminated hospital later qualify as an emergency provider, billings are handled by the designated emergency FI.

140.2.5.3 - Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate, a file will be updated annually (usually each October/November).

Patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111), which includes both Condition Code 04 and the CMG code from the IRF PAI, to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for Fiscal Year 2007 and beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

IRFs that received LIP payments during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

Informational Only Claim Elements:

- Covered 111 TOB
- Condition Code 04
- Medicare Fee-for-Service is the primary payer
- There is no MSP
- *Medicare beneficiary identifier*
- For claims prior to October 1, 2011, report the Revenue Code 0024 line containing CMG A9999 and, instead of inputting the transmission date of the IRF-PAI in the service date field (as is required for FFS claims), input the discharge date as a default for these informational only claims. The discharge date is required on informational only claims to reduce reporting burden for IRFs who may be submitting "old" informational only claims.

NOTE: Effective January 1, 2011, do not report the service date for the revenue code 0024 line. Instead, use occurrence code 50 in place of the service date to report the default discharge date for informational only claims**.**

- Effective October 1, 2011, report the Revenue Code 0024 line containing the CMG from the IRF-PAI and the transmission date of the IRF-PAI in the occurrence code 50 and date field (as is required for FFS claims).

- All other required claim elements

The SSI/Medicare beneficiary data for IRF PPS is available to A/B MACs (A) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. A/B MACs (A) will use this information to update their provider specific file. The files are located at the following CMS Web site address: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html. Select Inpatient Rehabilitation Facility PPS, then select, from the list at the left, SSI Data.

A/B MACs (A) use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. A/B MACs (A) make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the A/B MAC (A) settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The A/B MAC (A) uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation) is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a

patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, CMS recognizes the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the A/B MAC (A) must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

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

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

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

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

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

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

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

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

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

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

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

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §140.2.8. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount, then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount, then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

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

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

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

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

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

Table 1: Data Elements for FISS Extract

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

List of Data Elements for FISS Extract
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; ‘Y’ = MSP, ‘blank’ = no MSP
Reason Code
HMO-IME Indicator
Filler

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes
Type of Day	Description	Eligible Title XIX Day
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under	No.

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

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

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

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

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

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

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

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

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

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

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

14) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the

time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.

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

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

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

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

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

Table 1: Data Elements for FISS Extract

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

List of Data Elements for FISS Extract
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; ‘Y’ = MSP, ‘blank’ = no MSP
Reason Code

List of Data Elements for FISS Extract
HMO-IME Indicator
Filler

170.1.3 - Completion of the Notice of Election for RNHCI

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Elections, revocations and cancellations of elections may be submitted to the contractor via the paper Form CMS-1450 or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ASC X12 837 institutional claim format) does not support the data requirements of these transactions.

This section gives detailed information only for items required for the notice of election and related transactions. The RHNCI does not need to complete items not listed.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction.

The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit - Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D - Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the contractor for processing.

Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

Required - (If available) The RNHCI enters the month, day, and year of birth. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000.

National Provider Identifier

Required - The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's Medicare card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient's *Medicare beneficiary identifier*. The RNHCI enters the *identifier* as it appears on the patient's Medicare Card, Social Security Award Certificate, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, etc., or as reported by the Social Security Office.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing RNHCI claims is the ASC X12 837 institutional claim transaction. Since the data structure of the ASC X12 837 institutional claim transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the Form CMS-1450 paper claim.

Both the electronic claim transaction and the paper claim form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/Medicare Record Number

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

1st Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency	**Definition**
0-Nonpayment/zero claims	Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 below.
l-Admit Through Discharge Claims	Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.

2-Interim-First Claim	Use for the first of an expected series of payment bills for the same confinement or course of treatment for which Medicare utilization is chargeable.
3-Interim-Continuing Claim	Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.
4-Interim-Last Claim	Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill is the discharge date for this confinement.
7-Replacement of Prior Claim	Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill. Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

Patient's Name

Required - The RNHCI must enter the beneficiary's last name, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The RNHCI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

Sex

Required - The RNHCI must enter an “M” for male or an “F” for female.

Admission Date

Required - The RNHCI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

Type of Admission

Required - The RNHCI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3	Elective	The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information Not Available	Self-explanatory

Point of Origin for Admission

Required - The RNHCI must enter the code indicating the beneficiary's point of origin. The RNHCI may use any valid point of origin code that applies to the particular admission.

Patient Discharge Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period. The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may enter any number of condition codes to describe conditions that apply to the billing period. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RHNCI must indicate whether the beneficiary elects to use lifetime reserve days. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68. If the beneficiary elects not to use lifetime reserve days, the RNHCI must report condition code 67.

Occurrence Codes and Dates

Conditional - The RNHCI may enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. Occurrence codes are 2 alphanumeric digits, and are reported with a corresponding date.

If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI reports occurrence code A3.

Occurrence Span Code and Dates

Conditional - The RNHCI may enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code.

If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI, the RNHCI reports occurrence span code 74.

Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, FL 4 = 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted.

Value Codes and Amounts

Required - The RNHCI must report utilization days using the value codes described below.

Covered Days - The RNHCI must use value code 80 to enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as non-covered, the day of discharge, and the day of death.

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

Non-covered Days - The RNHCI must use value code 81 to enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Non-covered days include:

- Days not falling under the guarantee of payment provision. See section 40.1. E.
- Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;
- Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them.
- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, section 50);
- Days after the date covered services ended, such as non-covered level of care;
- Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6;
- Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, section 10.6.4;

The RNHCI enters in "Remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for each category of non-covered days (e.g., "5 leave days").

Day of discharge or death is not counted as a non-covered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

Coinsurance Days - The RNHCI must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period.

Lifetime Reserve Days - The RNHCI must use value code 83 to enter the number of lifetime reserve days the beneficiary elected to use during this billing period.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Conditional - The RNHCI may at their option enter any number of other value codes and related dollar amount(s) to identify data necessary for the processing of this claim. Value codes are 2 alphanumeric digits, and a corresponding value amount. Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence.

Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line explains each charge. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	Description
0001	Total Charges
0120	Semi-Private Room
0270	Supplies (non-religious, as covered by Medicare)

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. On paper claims, the RNHCI must enter revenue code "000l" to report a total of the charges on the claim.

The RNHCI should list revenue codes other than revenue code “0001” in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible.

Units of Service

Required - The RNHCI must enter the number of days for accommodations revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a non-covered charge and you can bill the beneficiary if that is your usual practice and if the beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in non-covered charges.

Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. On paper claims, the last revenue code entered in revenue

code "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

When submitting charges (covered/non-covered):

- Medicare is restricted by law and court order from paying for the religious portion of care or the training of personnel that provide that care. Additionally Medicare does not pay either based on charges or costs for training of nonmedical personnel. RNHCIs do not receive full Medicare payment for a beneficiary's stay since the beneficiary is fiscally responsible for the religious aspects of care. Therefore, the original Medicare or Medicare health plan rate may be significantly lower than the RNHCI private pay rate that includes religious charges.

- As medical procedures are not performed in a RNHCI, the use of high cost medical supplies are not separately payable. Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads) are not separately payable in a RNHCI. The use of diapers, incontinence pads, chux/underpads, feminine hygiene products, tissues, and the materials for simple dressings (cleansing and bandaging) are included in the daily room and board portion of the charges and should not be reported separately as supplies.

- Medical equipment (e.g., wheelchair, walker, crutches) are institution inventory items for beneficiary use in the RNHCI. The use of these items during the beneficiary stay is part of the daily interim payment to the RNHCI. To receive Medicare payment for durable medical equipment (DME) following a RNHCI stay, a beneficiary would need to meet all of the criteria, including medical necessity, and obtain a physician order or prescription. A RNHCI is not authorized as a Medicare supplier and, therefore, may not offer DME items for purchase to beneficiaries.

- Nonmedical nursing personnel, for Medicare payment purposes, perform services (e.g., serving meals, assisting with activities of daily living) that are strictly nonmedical/non-religious. The statute and court order mandates only the coverage and payment under Part A for reasonable and necessary nonmedical/non-religious care.

- Medicare payment for religious/nonmedical nursing personnel in a RNHCI, as other inpatient facilities, is a component of the per diem rate and is not separately payable.

Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff, or convenience items that are not part of the Medicare daily interim payment rate.)

Examples of non-covered charges:

- Non-covered religious items include but are not limited to religious publications, religious recordings, any equipment for the use of those recordings, any reproduction costs for these materials, and attendance at religious meetings.

- Religious sessions with RNHCI staff or outside associates.

- Expenses related to student programs/subsistence, staff education/training, travel, or relocation to be factored into the development of charges for covered patient care services.

- Stays, items, and services that are not substantiated by appropriate documentation in the beneficiary's utilization review file or care record.

- Convenience items (e.g., telephone, computer, beautician/barber).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A supply information needed by the payer named. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

National Provider Identifier

Required - The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, the RNHCI must enter the *Medicare beneficiary identifier*. The RNHCI must show the *Medicare beneficiary identifier* as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, or as reported by the Social Security Office.

Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through" dates before implementation of ICD-10, the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause"). To satisfy this requirement on claims with Statement Covers "Through" dates on or after the implementation of ICD-10, the RNHCI may report ICD-10 code R69 (defined "illness, unspecified").

Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through" dates before the implementation of ICD-10, the RNHCI may report ICD-9 code V62.6 (defined "refusal of treatment for reasons of religion or conscience"). To satisfy this requirement on claims with Statement Covers "Through" dates on or after the implementation of ICD-10, the RNHCI may report ICD-10 code Z53.1 (defined "procedure and treatment not carried out because of patient's decision for reasons of belief").

The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other fields relating to medical diagnoses and medical procedures.

The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other fields relating to medical diagnoses and medical procedures.

Attending Provider

Required - While the participation of an attending provider is not consistent with the nonmedical nature of RNHCI services, reporting an attending provider is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI must report the name and NPI of their director of nursing.

Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date

Required - If using the hard copy claim, an RNHCI representative makes sure the claim record is complete and accurate before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

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

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

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

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

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

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

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

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

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

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

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

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §190.7.2.4. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

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

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part II line 2, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of

Worksheet E-3, Part II of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 29 of Worksheet E-3, Part II.

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

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

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

Table 1: Data Elements for FISS Extract

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

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

200.2 - Submission of Informational Only Bills for Maryland Waiver Hospitals and Critical Access Hospitals (CAHs)

(Rev.4236, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12- 19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Acute care hospitals already submit informational only bills for purposes of including Part C days in the Disproportionate Share (DSH) calculations, as explained in Section 20.3 above. However, Maryland waiver hospitals and CAHs do not currently submit informational only bills. In order for CMS to capture Part C days for purposes of calculating EHR payments, Maryland waiver hospitals and CAHs must submit informational only claims to Medicare, effective for discharges October 1, 2010. Informational only claims are claims billed for patients enrolled in a Medicare Advantage (MA) Plan and contain a condition the following elements:

- Covered 11X TOB (not 110)

- Condition Code 04
- Medicare is the primary payer
- There is no MSP
- *Medicare beneficiary identifier*
- All other required claim elements