CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2323	**Date: October 26, 2011**
	Change Request 7609

SUBJECT: Inpatient Rehabilitation Facility (IRF) and Inpatient Psychiatric Facility (IPF) Cost-to-Charge Ratios (CCRs)

I. SUMMARY OF CHANGES: Cost report worksheet D-4 shall now be used to identify routine Medicare charges for IRF and IPF units.

EFFECTIVE DATE: November 28, 2011
IMPLEMENTATION DATE: November 28, 2011

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	3/140.2.6/Cost-to-Charge Ratios
R	3/190.7.2.2/Determining the Cost-to-Charge Ratio

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2323	Date: October 26, 2011	Change Request: 7609

SUBJECT: Inpatient Rehabilitation Facility (IRF) and Inpatient Psychiatric Facility (IPF) Cost-to-Charge Ratios (CCRs)

Effective Date: November 28, 2011

Implementation Date: November 28, 2011

I. GENERAL INFORMATION

This instruction provides updated information for determining IRF and IPF CCRs.

A. Background: Change Request 7192, Transmittal 2111, published December 3, 2010, included changes to the Medicare Claims Processing Manual, Chapter 3, Section 140.2.6. These revisions included a change in how Medicare contractors calculate CCRs for IRF units. The change inadvertently excluded ancillary charges from being included as part of total Medicare charges. In determining CCRs, total Medicare charges should include both routine and ancillary charges.

In order to identify routine Medicare charges for IRF and IPF units, the Medicare Claims Processing Manual instructs Medicare contractors to estimate routine charges using worksheets D-1 and C. However, cost report worksheet D-4 is now to be used to identify routine Medicare charges for IRF and IPF units, the same way the worksheet is currently used to identify routine Medicare charges for freestanding IRFs and IPF hospitals.

B. Policy: Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Sections 140.2.6 and 190.7.2.2, provide policy on determining cost-to-charge ratios for IRFs and IPFs, respectively. In identifying routine Medicare charges for freestanding IRFs and IPF hospitals and for IRF and IPF units, Medicare contractors shall use worksheet D-4, and total Medicare charges must include both routine and ancillary charges.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7609.1	Contractors shall recognize the revised instructions established in Chapter 3, §140.2.6 and § 190.7.2.2 of the Medicare Claims Processing Manual pertaining to the calculation of CCRs for IRFs and IPFs.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

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

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): Hillary Loeffler, (410) 786-0456, Hillary.Loeffler@cms.hhs.gov

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

140.2.6 - Cost-to-Charge Ratios

(Rev. 2323, Issued: 10-26-11, Effective: 11-28-11, Implementation: 11-28-11)

For discharges beginning on and after January 1, 2002 thru September 30, 2003, the Medicare contractor shall use the instructions for calculating the CCR for purposes of determining outlier payments under the IRF PPS set forth in Transmittal A-01-131.

For discharges beginning on or after October 1, 2003, the Medicare contractor shall use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period), specific to freestanding IRFs or for IRFs that are distinct part units of acute care hospitals in accordance with the formulas set forth below.

Effective October 1, 2003, if an IRF's CCR is above the applicable ceiling set forth annually in the IRF PPS notices published in the **Federal Register** it is considered to be statistically inaccurate. As a result, CMS will assign the IRF an appropriate national average CCR. CMS does not use a lower threshold; an IRF will receive their actual CCR, no matter how low their ratio falls.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of the inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swingbed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file (PSF) contains a field for the operating CCR (Field 25; file position 102-105) and for the capital CCR (Field 42; file position 203-206). Because the CCR computed for the IRF PPS includes routine, ancillary, and capital costs, the CCR for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

The Medicare contractor shall continue to update the IRF's CCR each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the PSF not later than 30 days after the date of the latest settlement used in calculating the CCR.

A - Calculating Medicare CCRs for Freestanding IRFs

1) *Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101).*

2) *Identify total Medicare charges (the sum of routine and ancillary charges), from Worksheet D-4, Column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.*

3) Divide the Medicare costs by the Medicare charges to compute the CCR.

B - Calculating Medicare CCRs for IRF Distinct Part Units

1) *Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101).*

2) *Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.*

3) *Divide the Medicare costs by the Medicare charges to compute the CCR.*

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IRF unit that has the letter "T" or "R" in the third position of the Medicare provider number.

C - Calculating Medicare CCRs for New IRFs

In the case of a New IRF unit (defined in 42 C.F.R. 412.30) or a New Inpatient Rehabilitation Hospital (defined as a hospital that has never entered into a provider agreement with the Secretary), the Medicare contractor shall use a national average CCR based on the facility location of either urban or rural. The national average CCRs applicable to IRFs shall be found in each year's annual notice of prospective payment rates published in the Federal Register.

The national average CCR will be used until the IRF's actual CCR can be computed using the first tentative settled or final settled cost report data, which will then be used for the subsequent cost report periods.

We NOTE, the policies in §§ E and F below can be applied as an alternative to the national average CCR.

For those IRFs assigned the national average CCR, the CCR must be updated every October 1 based on the latest national average CCRs published in each year's IRF PPS annual notice of prospective payment rates until the IRF is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D- Mergers, Conversion and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IRF with the surviving provider number. If a new provider number is issued (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement), the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

When errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact the CMS Central Office to seek guidance. Likewise, when a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR; Medicare contractors should contact the CMS Central Office for further instructions.

E – Alternative CCRs

The CMS may direct the Medicare contractor to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentative settled cost report, if it believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor should contact the CMS Regional Office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in an IRF's operations occurs which materially affects the IRF's costs and/or charges. Notification to the CMS Central Office shall be sent to the mailing address or email address provided in Part (f) below. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the Medicare contractor for use of an alternative CCR. Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

F – Request for Use of a Different CCR by the IRF

Also, an IRF will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IRF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the IRF, the Medicare contractor notifies the CMS Regional Office and CMS Central Office of such a request. The CMS Regional Office, in conjunction with CMS Central Office, will approve or deny any request by the IRF for use of a different CCR. Medicare contractors shall send requests to the CMS Central Office at the following address or email address:

CMS
C/O Division of Institutional Post Acute Care
7500 Security Blvd
Mail Stop C5-06-27
Baltimore, MD 21244

irf_outlier_reconciliation@cms.hhs.gov

Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

G - Notification to Facilities Under the IRF PPS

The Medicare contractor shall notify an IRF whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.

H – Maintaining a History of CCRs and Other Fields in the Provider Specific File

When recalculating claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the PSF. This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: 21 -Case Mix Adjusted Cost Per Discharge, 24 -Bed Size, 25 -Operating Cost to Charge Ratio, 27 -SSI Ratio, -28 -Medicaid Ratio and 49 –Capital IME. A separate history outside of the PSF is not necessary. The only instances a

Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev. 2323, Issued: 10-26-11, Effective: 11-28-11, Implementation: 11-28-11)

For discharges in cost reporting periods beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine the IPF's CCR. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals:

1) *Identify total Medicare costs from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).*

2) *Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.*

3) *Divide the Medicare costs by the Medicare charges to compute the CCR.*

Distinct Part Units

For IPFs that are distinct part psychiatric units:

1) *Identify total Medicare costs from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101).*

2) *Identify total Medicare charges (the sum of routine and ancillary charges) from Worksheet D-4, Column 2, line 31 plus line 103 from the cost report; where possible, these charges should be confirmed with the PS&R data.*

3) *Divide the Medicare costs by the Medicare charges to compute the CCR.*

All references to Worksheets and specific line numbers shall correspond with the sub-provider identified as the IPF unit that has the letter "S" or "M" in the third position of the Medicare provider number.

A. Use of Alternative Data in Determining CCRs For IPFs Subject to the IPF PPS

Under 42 CFR 412.424(d)(3)(i,), for discharges in cost reporting periods beginning on or after January 1, 2005, CMS may direct Medicare contractors to use an alternative CCR to the CCRs from the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data.

B. Request by the IPF for use of a Different CCR

For discharges in cost reporting periods beginning on or after January 1, 2005, an IPF may request that an alternative CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office, in conjunction with the CMS Central Office, will approve or deny any request after evaluation by the Medicare contractor of the evidence presented by the IPF. Revised CCRs are applied prospectively to all IPF claims. Medicare contractors shall send notification to the CMS Central Office via the following address and e-mail address:

CMS
C/O Division of Chronic Care Management-IPF Outlier Team
7500 Security Blvd.
Mail Stop C5-05-27
Baltimore, MD. 21244
outliersipf@cms.hhs.gov

C. Application of National Average CCRs for IPFs

For discharges in cost reporting periods occurring on or after January 1, 2005, the Medicare contractor may use the national CCRs for an IPF in one of the following circumstances:

1. New IPFs that have not yet submitted their first Medicare cost report.

2. IPFs whose CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).

3. Other IPFs for whom the Medicare contractor obtains inaccurate or incomplete data with which to calculate a CCR.

For new IPFs, we are using the national CCRs until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period. **NOTE**: IPF PPS provides two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas. We computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs.

The policies in section E below can be applied as an alternative to the national average CCR.

For those IPFs assigned the national average CCR, the CCR must be updated every July 1 based on the latest national average CCRs published in each year's IPF annual notice of prospective payment

rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of part E and F of this section.

D. Notification to IPFs Under the IPF PPS of a Change in the CCR

The Medicare contractor shall notify an IPF whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to an IPF about a change to their CCR(s).

E. Ongoing CCR Updates Using CCRs From Tentative Settlements For Entities Subject to the IPF PPS

For discharges beginning on or after January 1, 2005, Medicare contractors are to use a CCR from the latest settled cost report or from the latest tentatively settled cost report (whichever is from the later period) to determine the IPF's CCR. Under the IPF PPS, Medicare contractors must update the IPFs CCR on the Provider Specific File to reflect the IPFs CCR from the most recent tentative settlements or final settled cost reports, (whichever is the later period). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCR.

Subject to the approval of CMS, an IPF's CCR may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. A revised CCR will be applied prospectively to all IPF PPS claims processed after the update.

F. Alternative CCRs

Effective for discharges in cost reporting periods beginning on or after January 1, 2005, the CMS Central Office may direct Medicare contractors to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentatively settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the Medicare contractor shall contact the CMS Central Office to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IPF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office and CMS Central Office must approve any such request after evaluation by the Medicare contractor of the evidence presented by the IPF.

G. IPF Mergers, Ownership Changes, and Errors with CCRs

Effective April 1, 2011, in the case of a merger, the Medicare contractor shall use the CCR from the IPF with the surviving provider number. If a new provider number (i.e., a new provider agreement is signed because the new owner refused assignment of the existing provider agreement) is issued the Medicare contractor shall use the national CCR based on the facility location of either urban or rural.

In instances where errors related to CCRs and/or outlier payments are discovered, Medicare contractors shall contact CMS Central Office to seek guidance. Medicare contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

If a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR, Contractors shall contact the CMS regional and Central Office for further instructions. Contractors may contact the CMS Central Office via the address and email address listed in part B of this section.

H. Maintaining a History of CCRs and Other Fields in the Provider Specific File

When reprocessing claims due to outlier reconciliation, Medicare contractors shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.