CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3590	**Date: August 1, 2016**
	Change Request 9570

Transmittal 3511, dated April 29, 2016, is being rescinded and replaced by Transmittal 3590, dated August 1, 2016 to make technical changes developed during Agile meeting discussions with Fiscal Intermediary Standard System (FISS) Maintainer. Specifically we: reworded business requirements (BRs) 9570.3, 9570.11, 9570.12, 9570.15 and 9570.17, added Medicare Administrative Contractors (MACs) as responsible for BR 9570.15.1, added new BR 9570.18 and updated the location of the Islet Add-on payment amount in the Manual attachment. All other information remains the same.

SUBJECT: Changes to the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific File (PSF) for Low-Volume Hospital Payment Adjustment Factor and New Inpatient Prospective Payment System (IPPS) Pricer Output Field for Islet Isolation Add-on Payment

I. SUMMARY OF CHANGES: This change request adds the low-volume hospital payment adjustment factor to the PSF and adds an output field for the islet isolation cell transplantation add-on payment.

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Addendum A/Provider Specific File
R	3/20/1.2.7/ Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

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: 3590	Date: August 1, 2016	Change Request: 9570

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SUBJECT: Changes to the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific File (PSF) for Low-Volume Hospital Payment Adjustment Factor and New Inpatient Prospective Payment System (IPPS) Pricer Output Field for Islet Isolation Add-on Payment

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I. GENERAL INFORMATION

A. Background: The Affordable Care Act and subsequent legislation provides an expansion to the payment adjustment for hospitals that qualify as a low-volume hospital. Currently, the low-volume hospital payment adjustment factor, used to calculate the payment adjustment, resides in the IPPS Pricer. In order to make changes to the payment adjustment amounts more efficient, we are adding the low-volume hospital payment adjustment factor to the PSF which will be passed into the IPPS Pricer.

CMS Certification Numbers (CCNs) for Medicare Providers consist of 6 digits with the first 2 digits identifying the State in which the provider is located. Periodically, States exhaust their supply of CCNs for multiple provider types which requires CMS to assign new state codes. To make changes to state codes used in the IPPS and Long Term Care Hospital (LTCH) Pricers more efficient, we are instructing the Fiscal Intermediary Shared System (FISS) to pass the state code in the PSF to the IPPS and LTCH Pricers.

Change Request 5505, Transmittal 1192 issued March 2, 2007, implemented an add-on payment for islet isolation services. Currently, the IPPS Pricer combines the add-on payment for islet isolation cell transplantation services with the new technology add-on payment. Islet isolation cell transplantation is not a new technology and the add-on payment should be reported separately.

B. Policy: This CR does not contain new policy.

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	
9570.1	CMS shall expand the inpatient PSF record to include a new 7-byte numeric field to carry the low-volume									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	hospital payment adjustment factor defined as follows: Format - 9V9(6) Title – LV Adjustment Factor Description – Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital.									
9570.2	The IPPS Pricer shall expand the input record to include the new 7-byte Low-Volume Hospital Payment Adjustment Factor.									IPPS Pricer
9570.3	The contractor shall modify its inpatient PSF record to include either a blank or the new 7-byte Low-Volume Hospital Payment Adjustment Factor field to allow Medicare Administrative Contractors (MACs) to input when CMS provides it to them. NOTE: The LV adjustment factor shall be greater than 0 (no adjustment) and less than or equal to 0.250000.					X				
9570.3.1	The contractor shall update Reports 710, 964 and 967 to accommodate the new low volume adjustment factor field.					X				
9570.4	The contractor shall update the LV Adjustment Factor in the PSF with the calculated adjustment factor provided by CMS.	X								
9570.5	The contractor shall pass the LV Adjustment Factor to the IPPS Pricer.					X				
9570.6	The IPPS Pricer shall report the Islet Isolation Add-on payment in the new field in the output record (see attachment A).									IPPS Pricer, PS&R
9570.7	The contractor shall read the Islet Isolation Add-on payment amount in the new Pricer output field and move it to the payer only value code 'Q7'.					X				Cost Report, PS&R
9570.8	The contractor shall not pass payer only value code 'Q7' to the Benefits Coordination & Recovery Contractor (BCRC).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9570.9	The contractor shall send the amount in value code 'Q7' to HIGLAS on the 837 for payment to PIP providers.					X				HIGLAS
9570.9.1	HIGLAS shall receive the ISLET Isolation Add-on amount in the HIGLAS Invoice Amount field with the HIGLAS Invoice Qualifier ‘PI’ on the HIGLAS 837 for payment on PIP providers.					X				HIGLAS
9570.9.2	HIGLAS shall receive the sum of all the Add-on amounts, including the ISLET Isolation Add-on amount, if multiple Add-on payments are on the claim in the HIGLAS Invoice Amount field with the HIGLAS Invoice Qualifier ‘PM’ on the HIGLAS 837 for payment on PIP providers.					X				HIGLAS
9570.10	The Provider and Statistical Reimbursement (PS&R) System and cost report form shall create a separate field to display the Islet Isolation Add-on payment amount.									Cost Report, PS&R
9570.11	The contractor shall report the islet isolation add-on qualifier ‘ZO’ in the AMT01 segment and the payment amount in the AMT02 segment of the 2100 loop.					X				
9570.12	The contractor shall report the islet isolation add-on payment amount in value code 'Q7' in the CLP04 total payment amount; and in the PLB AMT segment with Qualifier ‘CSZO’ and amount for PIP providers.					X				
9570.13	The contractor shall report the islet add-on payment amount in value code 'Q7' as a separate amount on the standard paper remittance at both the detail and summary levels.					X				
9570.14	The contractor shall add the new PPS-ISLET-ADD-ON-AMT field, identified in bold italics in the attached update to Publication 100-04, Chapter 3, Section 20.1.2.7, to the FISS Lump Sum Utility.					X				
9570.15	The contractor shall pass the lowest State code, date element 19, file positions 76-77 in the PSF to the field named W-P-NEW-STATE-CODE in the IPPS Pricer and the field named P-NEW-STATE-CODE in the LTCH Pricer. See layouts in Attachments B and C.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9570.15.1	The contractor shall ensure the lowest state code for a given state is displayed.	X				X				
9570.16	The IPPS Pricer and LTCH Pricer shall accept the 2 position state code field from FISS.									IPPS Pricer, LTCH Pricer
9570.17	The contractor shall update the PC Print software to report the Islet Add-on payment using the amount in Loop 2100 AMT02 segment when AMT01 segment equals 'ZO'.					X				
9570.18	The contractor shall ensure if the Temporary Relief Indicator code is 'Y', the LV payment adjustment is a value greater than zero and less than or equal to 0.250000. If the LV payment adjustment is a value greater than zero and less than or equal to 0.25000 the contractor shall ensure the Temporary Relief Indicator code is equal to 'Y'.					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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@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: 3

Attachment A – Revision to IPPS Output record for CR9570
Note: The line numbers will change in the production version of the IPPS Pricer

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151100           01  PPS-ADDITIONAL-VARIABLES.
151200     05  PPS-HSP-PCT              PIC 9(01)V9(02).
151300     05  PPS-FSP-PCT              PIC 9(01)V9(02).
151400     05  PPS-NAT-PCT              PIC 9(01)V9(02).
151500     05  PPS-REG-PCT              PIC 9(01)V9(02).
151600     05  PPS-FAC-SPEC-RATE        PIC 9(05)V9(02).
151700     05  PPS-UPDATE-FACTOR        PIC 9(01)V9(05).
151800     05  PPS-DRG-WT               PIC 9(02)V9(04).
151900     05  PPS-NAT-LABOR            PIC 9(05)V9(02).
152000     05  PPS-NAT-NLABOR           PIC 9(05)V9(02).
152100     05  PPS-REG-LABOR            PIC 9(05)V9(02).
152200     05  PPS-REG-NLABOR           PIC 9(05)V9(02).
152300     05  PPS-OPER-COLA            PIC 9(01)V9(03).
152400     05  PPS-INTERN-RATIO         PIC 9(01)V9(04).
152500     05  PPS-COST-OUTLIER         PIC 9(07)V9(09).
152600     05  PPS-BILL-COSTS           PIC 9(07)V9(09).
152700     05  PPS-DOLLAR-THRESHOLD     PIC 9(07)V9(09).
152800     05  PPS-DSCHG-FRCTN          PIC 9(1)V9999.
152900     05  PPS-DRG-WT-FRCTN         PIC 9(2)V9999.
153000     05  PPS-CAPITAL-VARIABLES.
153100         10  PPS-CAPI-TOTAL-PAY       PIC 9(07)V9(02).
153200         10  PPS-CAPI-HSP             PIC 9(07)V9(02).
153300         10  PPS-CAPI-FSP             PIC 9(07)V9(02).
153400         10  PPS-CAPI-OUTLIER         PIC 9(07)V9(02).
153500         10  PPS-CAPI-OLD-HARM        PIC 9(07)V9(02).
153600         10  PPS-CAPI-DSH-ADJ         PIC 9(07)V9(02).
153700         10  PPS-CAPI-IME-ADJ         PIC 9(07)V9(02).
153800         10  PPS-CAPI-EXCEPTIONS      PIC 9(07)V9(02).
153900     05  PPS-CAPITAL2-VARIABLES.
154000         10  PPS-CAPI2-PAY-CODE       PIC X(1).
154100         10  PPS-CAPI2-B-FSP          PIC 9(07)V9(02).
154200         10  PPS-CAPI2-B-OUTLIER      PIC 9(07)V9(02).
154300
154400     05  PPS-OTHER-VARIABLES.
154500         10  PPS-NON-TEMP-RELIEF-PAYMENT    PIC 9(07)V9(02).
154600         10  PPS-NEW-TECH-PAY-ADD-ON        PIC 9(07)V9(02).
                10 PPS- ISLET-ISOL-PAY-ADD-ON     PIC 9(07)V9(02).
154700         10  PPS-LOW-VOL-PAYMENT          PIC 9(07)V9(02).
154800         10  PPS-VAL-BASED-PURCH-PARTIPNT   PIC X.
154900         10  PPS-VAL-BASED-PURCH-ADJUST     PIC 9V9(11).
155000         10  PPS-HOSP-READMISSION-REDU      PIC X.
155100         10  PPS-HOSP-HRR-ADJUSTMT          PIC 9V9(4).
155200         10  PPS-OPERATNG-DATA.
155300             15  PPS-MODEL1-BUNDLE-DISPRCNT  PIC V999.
155400             15  PPS-OPER-BASE-DRG-PAY       PIC 9(08)V99.
155500             15  PPS-OPER-HSP-AMT            PIC 9(08)V99.
155600
155700     05  PPS-PC-OTH-VARIABLES.
155800         10  PPS-OPER-DSH             PIC 9(01)V9(04).
155900         10  PPS-CAPI-DSH             PIC 9(01)V9(04).
156000         10  PPS-CAPI-HSP-PCT         PIC 9(01)V9(02).
156100         10  PPS-CAPI-FSP-PCT         PIC 9(01)V9(04).
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156200        10  PPS-ARITH-ALOS               PIC 9(02)V9(01).
156300        10  PPS-PR-WAGE-INDEX            PIC 9(02)V9(04).
156400        10  PPS-TRANSFER-ADJ             PIC 9(01)V9(04).
156500        10  PPS-PC-HMO-FLAG              PIC X(01).
156600        10  PPS-PC-COT-FLAG              PIC X(01).
156700        10  PPS-OPER-HSP-PART2           PIC 9(07)V9(02).
156800        10  PPS-BUNDLE-ADJUST-PAY        PIC S9(07)V99.
156900
157000     05  PPS-ADDITIONAL-PAY-INFO-DATA.
157100        10 PPS-UNCOMP-CARE-AMOUNT        PIC S9(07)V9(02).
157200        10 PPS-BUNDLE-ADJUST-AMT         PIC S9(07)V9(02).
157300        10 PPS-VAL-BASED-PURCH-ADJUST-AMT  PIC S9(07)V9(02).
157400        10 PPS-READMIS-ADJUST-AMT        PIC S9(07)V9(02).
157500     05  PPS-ADDITIONAL-PAY-INFO-DATA2.
157600        10  PPS-HAC-PROG-REDUC-IND      PIC X.
157700        10  PPS-EHR-PROG-REDUC-IND      PIC X.
157800        10  PPS-EHR-ADJUST-AMT          PIC S9(07)V9(02).
157900        10  PPS-STNDRD-VALUE            PIC S9(07)V9(02).
158000        10  PPS-HAC-PAYMENT-AMT         PIC S9(07)V9(02).
158100        10  PPS-FLX7-PAYMENT            PIC S9(07)V9(02).
158200     05 PPS-FILLER                      PIC X(0897).
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Attachment B PSF Layout w State Code Field IPPS PRICER

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01  W-PROV-NEW-HOLD.
   02  W-PROV-NEWREC-HOLD1.
      05  W-P-NEW-NPI10.
         10  W-P-NEW-NPI8          PIC X(08).
         10  W-P-NEW-NPI-FILLER     PIC X(02).
      05  W-P-NEW-PROVIDER-OSCAR-NO.
         10  W-P-NEW-STATE          PIC X(02).
         10  FILLER                 PIC X(04).
      05  W-P-NEW-DATE-DATA.
         10  W-P-NEW-EFF-DATE.
            15  W-P-NEW-EFF-DT-CC    PIC 9(02).
            15  W-P-NEW-EFF-DT-YY    PIC 9(02).
            15  W-P-NEW-EFF-DT-MM    PIC 9(02).
            15  W-P-NEW-EFF-DT-DD    PIC 9(02).
         10  W-P-NEW-FY-BEGIN-DATE.
            15  W-P-NEW-FY-BEG-DT-CC PIC 9(02).
            15  W-P-NEW-FY-BEG-DT-YY PIC 9(02).
            15  W-P-NEW-FY-BEG-DT-MM PIC 9(02).
            15  W-P-NEW-FY-BEG-DT-DD PIC 9(02).
         10  W-P-NEW-REPORT-DATE.
            15  W-P-NEW-REPORT-DT-CC PIC 9(02).
            15  W-P-NEW-REPORT-DT-YY PIC 9(02).
            15  W-P-NEW-REPORT-DT-MM PIC 9(02).
            15  W-P-NEW-REPORT-DT-DD PIC 9(02).
         10  W-P-NEW-TERMINATION-DATE.
            15  W-P-NEW-TERM-DT-CC   PIC 9(02).
            15  W-P-NEW-TERM-DT-YY   PIC 9(02).
            15  W-P-NEW-TERM-DT-MM   PIC 9(02).
            15  W-P-NEW-TERM-DT-DD   PIC 9(02).
      05  W-P-NEW-WAIVER-CODE         PIC X(01).
         88  W-P-NEW-WAIVER-STATE       VALUE 'Y'.
      05  W-P-NEW-INTER-NO            PIC X(05).
      05  W-P-NEW-PROVIDER-TYPE       PIC X(02).
      05  W-P-NEW-CURRENT-CENSUS-DIV   PIC X(01).
      05  W-P-NEW-MSA-DATA.
         10  W-P-NEW-CHG-CODE-INDEX    PIC X.
         10  W-P-NEW-GEO-LOC-MSA       PIC X(04) JUST RIGHT.
         10  W-P-NEW-WAGE-INDEX-LOC-MSA PIC X(04) JUST RIGHT.
         10  W-P-NEW-STAND-AMT-LOC-MSA  PIC X(04) JUST RIGHT.
         10  W-P-NEW-STAND-AMT-LOC-MSA9
     REDEFINES W-P-NEW-STAND-AMT-LOC-MSA.
            15  W-P-NEW-RURAL-1ST.
               20  W-P-NEW-STAND-RURAL  PIC XX.
            15  W-P-NEW-RURAL-2ND       PIC XX.
      05  W-P-NEW-SOL-COM-DEP-HOSP-YR PIC XX.
      05  W-P-NEW-LUGAR               PIC X.
      05  W-P-NEW-TEMP-RELIEF-IND     PIC X.
      05  W-P-NEW-FED-PPS-BLEND-IND   PIC X.
      05  W-P-NEW-STATE-CODE     PIC 9(02).
      05  W-P-NEW-STATE-CODE-X REDEFINES
             W-P-NEW-STATE-CODE         PIC X(02).
      05  FILLER                  PIC X(03).
   02  W-PROV-NEWREC-HOLD2.
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   05  W-P-NEW-VARIABLES.
      10  W-P-NEW-FAC-SPEC-RATE     PIC  X(07).
      10  W-P-NEW-COLA              PIC  X(04).
      10  W-P-NEW-INTERN-RATIO      PIC  X(05).
      10  W-P-NEW-BED-SIZE          PIC  X(05).
      10  W-P-NEW-CCR               PIC  X(04).
      10  W-P-NEW-CMI               PIC  X(05).
      10  W-P-NEW-SSI-RATIO         PIC  X(04).
      10  W-P-NEW-MEDICAID-RATIO    PIC  X(04).
      10  W-P-NEW-PPS-BLEND-YR-IND  PIC  X(01).
      10  W-P-NEW-PRUP-UPDTE-FACTOR PIC  9(01)V9(05).
      10  W-P-NEW-DSH-PERCENT       PIC  V9(04).
      10  W-P-NEW-FYE-DATE.
         15  W-P-NEW-FYE-CC         PIC 99.
         15  W-P-NEW-FYE-YY         PIC 99.
         15  W-P-NEW-FYE-MM         PIC 99.
         15  W-P-NEW-FYE-DD         PIC 99.
   05  W-P-NEW-CBSA-DATA.
      10  W-P-NEW-CBSA-SPEC-PAY-IND   PIC X.
      10  W-P-NEW-CBSA-HOSP-QUAL-IND  PIC X.
      10  W-P-NEW-CBSA-GEO-LOC        PIC X(05) JUST RIGHT.
      10  W-P-NEW-CBSA-RECLASS-LOC    PIC X(05) JUST RIGHT.
      10  W-P-NEW-CBSA-STAND-AMT-LOC  PIC X(05) JUST RIGHT.
      10  W-P-NEW-CBSA-STAND-AMT-LOC9
    REDEFINES W-P-NEW-CBSA-STAND-AMT-LOC.
         15  W-P-NEW-CBSA-RURAL-1ST.
            20  W-P-NEW-CBSA-STAND-RURAL PIC 999.
         15  W-P-NEW-CBSA-RURAL-2ND       PIC 99.
      10  W-P-NEW-CBSA-SPEC-WAGE-INDEX     PIC 9(02)V9(04).
02  W-PROV-NEWREC-HOLD3.
   05  W-P-NEW-PASS-AMT-DATA.
      10  W-P-NEW-PASS-AMT-CAPITAL    PIC X(06).
      10  W-P-NEW-PASS-AMT-DIR-MED-ED PIC X(06).
      10  W-P-NEW-PASS-AMT-ORGAN-ACQ  PIC X(06).
      10  W-P-NEW-PASS-AMT-PLUS-MISC  PIC X(06).
   05  W-P-NEW-CAPI-DATA.
      15  W-P-NEW-CAPI-PPS-PAY-CODE   PIC X.
      15  W-P-NEW-CAPI-HOSP-SPEC-RATE PIC X(6).
      15  W-P-NEW-CAPI-OLD-HARM-RATE  PIC X(6).
      15  W-P-NEW-CAPI-NEW-HARM-RATIO PIC X(5).
      15  W-P-NEW-CAPI-CSTCHG-RATIO   PIC X(04).
      15  W-P-NEW-CAPI-NEW-HOSP       PIC X.
      15  W-P-NEW-CAPI-IME            PIC X(05).
      15  W-P-NEW-CAPI-EXCEPTIONS     PIC X(6).
   05  P-HVBP-HRR-DATA.
      15  W-P-NEW-VAL-BASED-PURCH-PARTIP   PIC X.
      15  W-P-NEW-VAL-BASED-PURCH-ADJUST   PIC 9V9(11).
      15  W-P-NEW-HOSP-READMISSION-REDU    PIC X.
      15  W-P-NEW-HOSP-HRR-ADJUSTMT        PIC 9V9(4).
   05  P-MODEL1-BUNDLE-DATA.
      15  W-P-MODEL1-BUNDLE-DISPRCNT   PIC V999.
      15  W-P-HAC-REDUC-IND            PIC X.
      15  W-P-UNCOMP-CARE-AMOUNT       PIC 9(07)V99.
      15  W-P-EHR-REDUC-IND            PIC X.
      15  W-P-LV-ADJ-FACTOR            PIC 9V9(6).
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05  FILLER                  PIC X(02).
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CR9570 Attachment C - Provider Specific File (PSF) Record for the LTCH Pricer with State Code Variable

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01  PROV-NEW-HOLD.
     02  PROV-NEWREC-HOLD1.
         05  P-NEW-NPI10.
             10  P-NEW-NPI8             PIC X(08).
             10  P-NEW-NPI-FILLER       PIC X(02).
         05  P-NEW-PROVIDER-NO.
             10  P-NEW-STATE            PIC 9(02).
             10  FILLER                 PIC X(04).
         05  P-NEW-DATE-DATA.
             10  P-NEW-EFF-DATE.
                 15  P-NEW-EFF-DT-CC    PIC 9(02).
                 15  P-NEW-EFF-DT-YY    PIC 9(02).
                 15  P-NEW-EFF-DT-MM    PIC 9(02).
                 15  P-NEW-EFF-DT-DD    PIC 9(02).
             10  P-NEW-FY-BEGIN-DATE.
                 15  P-NEW-FY-BEG-DT-CC PIC 9(02).
                 15  P-NEW-FY-BEG-DT-YY PIC 9(02).
                 15  P-NEW-FY-BEG-DT-MM PIC 9(02).
                 15  P-NEW-FY-BEG-DT-DD PIC 9(02).
             10  P-NEW-REPORT-DATE.
                 15  P-NEW-REPORT-DT-CC PIC 9(02).
                 15  P-NEW-REPORT-DT-YY PIC 9(02).
                 15  P-NEW-REPORT-DT-MM PIC 9(02).
                 15  P-NEW-REPORT-DT-DD PIC 9(02).
             10  P-NEW-TERMINATION-DATE.
                 15  P-NEW-TERM-DT-CC   PIC 9(02).
                 15  P-NEW-TERM-DT-YY   PIC 9(02).
                 15  P-NEW-TERM-DT-MM   PIC 9(02).
                 15  P-NEW-TERM-DT-DD   PIC 9(02).
         05  P-NEW-WAIVER-CODE          PIC X(01).
             88  P-NEW-WAIVER-STATE       VALUE 'Y'.
         05  P-NEW-INTER-NO             PIC 9(05).
         05  P-NEW-PROVIDER-TYPE        PIC X(02).
         05  P-NEW-CURRENT-CENSUS-DIV   PIC 9(01).
         05  P-NEW-CURRENT-DIV   REDEFINES
                    P-NEW-CURRENT-CENSUS-DIV   PIC 9(01).
         05  P-NEW-MSA-DATA.
             10  P-NEW-CHG-CODE-INDEX       PIC X.
             10  P-NEW-GEO-LOC-MSAX         PIC X(04) JUST RIGHT.
             10  P-NEW-GEO-LOC-MSA9   REDEFINES
                           P-NEW-GEO-LOC-MSAX  PIC 9(04).
             10  P-NEW-GEO-LOC-MSA-AST REDEFINES
                           P-NEW-GEO-LOC-MSA9.
                 15  P-NEW-GEO-MSA-1ST    PIC X.
                 15  P-NEW-GEO-MSA-2ND    PIC X.
                 15  P-NEW-GEO-MSA-3RD    PIC X.
                 15  P-NEW-GEO-MSA-4TH    PIC X.
             10  P-NEW-WAGE-INDEX-LOC-MSA   PIC X(04) JUST RIGHT.
             10  P-NEW-STAND-AMT-LOC-MSA    PIC X(04) JUST RIGHT.
             10  P-NEW-STAND-AMT-LOC-MSA9
                   REDEFINES P-NEW-STAND-AMT-LOC-MSA.
                 15  P-NEW-RURAL-1ST.
                     20  P-NEW-STAND-RURAL  PIC XX.
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                88  P-NEW-STD-RURAL-CHECK VALUE '  '.
            15  P-NEW-RURAL-2ND        PIC XX.
    05  P-NEW-SOL-COM-DEP-HOSP-YR PIC XX.
            88  P-NEW-SCH-YRBLANK    VALUE   '  '.
            88  P-NEW-SCH-YR82       VALUE   '82'.
            88  P-NEW-SCH-YR87       VALUE   '87'.
    05  P-NEW-LUGAR                    PIC X.
    05  P-NEW-TEMP-RELIEF-IND          PIC X.
    05  P-NEW-FED-PPS-BLEND-IND        PIC X.
    05  P-NEW-STATE-CODE               PIC 9(02).
    05  P-NEW-STATE-CODE-X REDEFINES
           P-NEW-STATE-CODE             PIC X(02).
    05  FILLER                         PIC X(03).
02  PROV-NEWREC-HOLD2.
    05  P-NEW-VARIABLES.
        10  P-NEW-FAC-SPEC-RATE     PIC  9(05)V9(02).
        10  P-NEW-COLA              PIC  9(01)V9(03).
        10  P-NEW-INTERN-RATIO      PIC  9(01)V9(04).
        10  P-NEW-BED-SIZE          PIC  9(05).
        10  P-NEW-CCR               PIC  9(01)V9(03).
        10  P-NEW-CMI               PIC  9(01)V9(04).
        10  P-NEW-SSI-RATIO         PIC  V9(04).
        10  P-NEW-MEDICAID-RATIO    PIC  V9(04).
        10  P-NEW-PPS-BLEND-YR-IND  PIC  X(01).
        10  P-NEW-PRUP-UPDTE-FACTOR PIC  9(01)V9(05).
        10  P-NEW-DSH-PERCENT       PIC  V9(04).
        10  P-NEW-FYE-DATE.
            15  P-NEW-FYE-CC        PIC 99.
            15  P-NEW-FYE-YY        PIC 99.
            15  P-NEW-FYE-MM        PIC 99.
            15  P-NEW-FYE-DD        PIC 99.
    05  P-NEW-CBSA-SPEC-PAY-IND       PIC X(01).
    05  P-NEW-HOSP-QUAL-IND           PIC X(01).
    05  P-NEW-GEO-LOC-CBSAX           PIC X(05) JUST RIGHT.
    05  P-NEW-GEO-LOC-CBSA9 REDEFINES
                    P-NEW-GEO-LOC-CBSAX PIC 9(05).
    05  P-NEW-GEO-LOC-CBSA-AST REDEFINES
                    P-NEW-GEO-LOC-CBSA9.
        10 P-NEW-GEO-LOC-CBSA-1ST     PIC X.
        10 P-NEW-GEO-LOC-CBSA-2ND     PIC X.
        10 P-NEW-GEO-LOC-CBSA-3RD     PIC X.
        10 P-NEW-GEO-LOC-CBSA-4TH     PIC X.
        10 P-NEW-GEO-LOC-CBSA-5TH     PIC X.
    05 P-NEW-GEO-LOC-CBSA-SIZE REDEFINES
                    P-NEW-GEO-LOC-CBSAX.
        10 P-NEW-GEO-LOC-CBSA-123     PIC X(03).
           88  P-NEW-RURAL-CBSA       VALUE '   '.
        10 P-NEW-GEO-LOC-CBSA-45      PIC X(02).
    05  FILLER                        PIC X(10).
    05  P-NEW-SPECIAL-WAGE-INDEX      PIC 9(02)V9(04).
02  PROV-NEWREC-HOLD3.
    05  P-NEW-PASS-AMT-DATA.
        10  P-NEW-PASS-AMT-CAPITAL    PIC 9(04)V99.
        10  P-NEW-PASS-AMT-DIR-MED-ED PIC 9(04)V99.
        10  P-NEW-PASS-AMT-ORGAN-ACQ  PIC 9(04)V99.
        10  P-NEW-PASS-AMT-PLUS-MISC  PIC 9(04)V99.
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05  P-NEW-CAPI-DATA.
    15  P-NEW-CAPI-PPS-PAY-CODE   PIC X.
    15  P-NEW-CAPI-HOSP-SPEC-RATE PIC 9(04)V99.
    15  P-NEW-CAPI-OLD-HARM-RATE  PIC 9(04)V99.
    15  P-NEW-CAPI-NEW-HARM-RATIO PIC 9(01)V9999.
    15  P-NEW-CAPI-CSTCHG-RATIO   PIC 9V999.
    15  P-NEW-CAPI-NEW-HOSP       PIC X.
    15  P-NEW-CAPI-IME            PIC 9V9999.
    15  P-NEW-CAPI-EXCEPTIONS     PIC 9(04)V99.
    15  P-VAL-BASED-PURCH-SCORE   PIC 9V999.
05  FILLER                        PIC X(18).
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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.3590, Issued: 08-01-16, Effective: 10-01-16, Implementation: 10-03-16)

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 #
Health Insurance Claim (HIC) Number
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)
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)

List of Data Elements for FISS Extract
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)
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)

List of Data Elements for FISS Extract
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

Addendum A - Provider Specific File

(Rev.3590, Issued: 08-01-16, Effective: 10-01-16, Implementation: 10-03-16)

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

<table>
<tr><th>Data Element</th><th>File Position</th><th>Format</th><th>Title</th><th>Description</th></tr>
<tr><td>2</td><td>11-16</td><td>X(6)</td><td>Provider Oscar No.</td><td>Alpha-numeric 6 character provider number. Cross check to provider type. Positions 3 and 4 of:
<table>
<tr><th>Provider #</th><th>Provider Type</th></tr>
<tr><td>00-08</td><td>Blanks, 00, 07-11, 13-17, 21-22; NOTE: 14 and 15 no longer valid, effective 10/1/12</td></tr>
<tr><td>12</td><td>18</td></tr>
<tr><td>13</td><td>23,37</td></tr>
<tr><td>20-22</td><td>02</td></tr>
<tr><td>30</td><td>04</td></tr>
<tr><td>33</td><td>05</td></tr>
<tr><td>40-44</td><td>03</td></tr>
<tr><td>50-64</td><td>32-34, 38</td></tr>
<tr><td>15-17</td><td>35</td></tr>
<tr><td>70-84, 90-99</td><td>36</td></tr>
</table>
Codes for special units are in the third position of the OSCAR number and should correspond to the appropriate provider type, as shown below (NOTE: SB = swing bed):
<table>
<tr><th>Special Unit</th><th>Prov. Type</th></tr>
<tr><td>M - Psych unit in CAH</td><td>49</td></tr>
<tr><td>R - Rehab unit in CAH</td><td>50</td></tr>
<tr><td>S - Psych Unit</td><td>49</td></tr>
<tr><td>T - Rehab Unit</td><td>50</td></tr>
<tr><td>U - SB for short-term hosp.</td><td>51</td></tr>
<tr><td>W - SB for LTCH</td><td>52</td></tr>
<tr><td>Y - SB for Rehab</td><td>53</td></tr>
<tr><td>Z - SB for CAHs</td><td>54</td></tr>
</table></td></tr>
<tr><td>3</td><td>17-24</td><td>9(8)</td><td>Effective Date</td><td>Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
Year: Greater than 82, but not greater than current year.
Month: 01-12
Day: 01-31</td></tr>
</table>

Data Element	File Position	Format	Title	Description
4	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Year: Greater than 81, but not greater than current year. Month: 01-12 Day: 01-31 Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date.
5	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
6	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting MAC ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another MAC, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing MAC. Likewise, if the provider identification number changes, the MAC must place a termination date in the PROV file transmitted to CO for the old provider identification number.
7	49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (Provider is not under PPS). N = not waived (Provider is under PPS).
8	50-54	9(5)	Intermediary Number	Assigned intermediary number.
9	55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, MACs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital

Data Element	File Position	Format	Title	Description
				(during cost reporting periods that began on or after April 1, 1990). Eff. 10/1/12, this provider type is no longer valid. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). Eff. 10/1/12, this provider type no longer valid. 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital/ Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demo Project – Phase II 33 Nursing Home Case Mix Quality Demo Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed **NOTE:** Provider Type values 49-54 refer to special unit designations that are assigned to the third position of the OSCAR number (See field #2 for a special unit-to-provider type cross-walk).

Data Element	File Position	Format	Title	Description
10	57	9(1)	Current Census Division	Must be numeric (1-9). Enter the Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, MACs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific **NOTE:** When a facility is reclassified for purposes of the standard amount, the MAC changes the census division to reflect the new standardized amount location.
11	58	X(1)	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
12	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
13	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
14	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.

Data Element	File Position	Format	Title	Description
15	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate. Eff. 10/1/12, MDHs are no longer valid provider types.
16	73	X(1)	Change Code for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
17	74	X(1)	Temporary Relief Indicator	Enter a “Y” if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank. **IPPS**: Effective October 1, 2004, code a “Y” if the provider is considered “low volume.” **IPF PPS**: Effective January 1, 2005, code a “Y” if the acute facility where the unit is located has an Emergency Department or if the freestanding psych facility has an Emergency Department. **IRF PPS:** Effective October 1, 2005, code a “Y” for IRFs located in the state and county in Table 2 of the Addendum of the August 15, 2005 **Federal Register** (70 FR 47880). The table can also be found at the following website: www.cms.hhs.gov/InpatientRehabFacPPS/07DataFiles.asp#topOfPage
18	75	X(1)	Federal PPS Blend Indicator	**HH PPS:** Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent **IRF PPS:** All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. **LTCH PPS:** Enter the appropriate code

Data Element	File Position	Format	Title	Description
				for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002. 1 Federal % 20 Facility% 80 2 40 60 3 60 40 4 80 20 5 100 00 **IPF PPS:** Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005. 1 Federal % 25 Facility% 75 2 50 50 3 75 25 4 100 00
19	76-77	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. MACs shall enter a "10" for Florida's state code. List of valid state codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
20	78-80	X(3)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000. Note that effective 10/1/12, MDHs are no longer valid provider types.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time

Data Element	File Position	Format	Title	Description
				equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The MAC is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for non-teaching hospitals. **IPF PPS:** Enter the ratio of residents/interns to the hospital's average daily census.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the MAC billing file, i.e., PS&R record. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero-fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.

Data Element	File Position	Format	Title	Description
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X(1)	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91.
30	120-125	9V9(5)	Special Provider Update Factor	Zero-fill for all hospitals after FY91. This Field is obsolete as of FY92.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero-fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD.
33	138	X(1)	Special Payment Indicator	Enter the code that indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
34	139	X(1)	Hospital Quality Indicator	Enter code to indicate that hospital meets criteria to receive higher payment per MMA quality standards. Blank = hospital does not meet criteria 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based Statistical Area (CBSA)	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Standardized Amount Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code)

Data Element	File Position	Format	Title	Description
				such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator field equals a "1" or "2."
39	161-166	9(4)V9(2)	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Must be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero-fill if this does not apply.
40	167-172	9(4)V9(2)	Pass Through Amount for Direct Medical Education	Per diem amount based on the interim payments to the hospital (See the Provider, Reimbursement Manual, §2405.2.). Zero-fill if this does not apply.
41	173-178	9(4)V9(2)	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, lung, pancreas, intestine and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero-fill if this does not apply.
42	179-184	9(4)V9(2)	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero-fill if this does not apply.
43	185	X(1)	Capital PPS Payment Code	Enter the code to indicate the type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old

Data Element	File Position	Format	Title	Description
				capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate
44	186-191	9(4)V9(2)	Hospital Specific Capital Rate	Must be present unless: • A "Y" is entered in the Capital Indirect Medical Education Ratio field; or • A“08” is entered in the Provider Type field; or • A termination date is present in Termination Date field. Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V9(2)	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V9(3)	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the MAC is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The MAC uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X(1)	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	This is for IPPS hospitals and IRFs only. Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 for inpatient acute hospital and §§140.2.4.3 and 140.2.4.5.1 for IRFs.) Zero-fill for a non-teaching

Data Element	File Position	Format	Title	Description
				hospital.
50	213-218	9(4)V9(2)	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-219	X	VBP Participant	Enter "Y" if participating in Hospital Value Based Purchasing. Enter "N" if not participating. Note if Data Element 34 (Hospital Quality Ind) is blank, then this field must = N.
52	220-231	9V9(11)	VBP Adjustment	Enter VBP Adjustment Factor. If Data Element 51 = N, leave blank.
53	232-232	X	HRR Indicator	Enter "0" if not participating in Hospital Readmissions Reduction program. Enter "1" if participating in Hospital Readmissions Reduction program and payment adjustment is not 1.0000. Enter "2" if participating in Hospital Readmissions Reduction program and payment adjustment is equal to 1.0000.
54	233-237	9V9(4)	HRR Adjustment	Enter HRR Adjustment Factor if "1" is entered in Data Element 53. Leave blank if "0" or "2" is entered in Data Element 53.
55	238-240	V999	Bundle Model 1 Discount	Enter the discount % for hospitals participating in Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61).
56	241-241	X	HAC Reduction Indicator	Enter a 'Y' if the hospital is subject to a reduction under the HAC Reduction Program. Enter a 'N' if the hospital is NOT subject to a reduction under the HAC Reduction Program.
57	242-250	9(7)V99	Uncompensated Care Amount	Enter the estimated per discharge uncompensated care payment amount calculated and published by CMS for each hospital
58	251-251	X	Electronic Health Records (EHR) Program Reduction	Enter a 'Y' if the hospital is subject to a reduction due to **NOT** being an EHR meaningful user. Leave blank if the hospital is an Electronic Health Records meaningful user.
59	252-*258*	*9V9(6)*	*LV Adjustment Factor*	*Enter the low-volume hospital payment adjustment factor calculated and published by the Centers for Medicare & Medicaid Services (CMS) for each eligible hospital.*
60	*259-260*	*X(9)*	*Filler*	