CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1030	**Date: AUGUST 11, 2006**
	Change Request 5238

This instruction is being re-communicated. The attached instruction was previously communicated as Sensitive, dated August 11, 2006. The attached instruction is no longer sensitive. The Transmittal Number, Issue Date and all other information remain the same.

SUBJECT: Policy Changes to the Fiscal Intermediary (FI) Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost to Charge Ratios (CCRs).

I. SUMMARY OF CHANGES: Effective for services furnished on or after January 1, 2007, we have changed the methodology for calculating the overall CCR for hospitals paid under OPPS which have nursing and allied health education programs. The calculation of the overall OPPS CCR that the FIs have used since issuance of Change Request (CR) 2197, Transmittal A-03-004, issued January 17, 2003, to determine outlier payment and payment for services paid at charges reduced to cost includes payments for paramedical education and allied health costs. These costs are excluded from OPPS and paid through cost report settlement. They cannot be included in calculating CCRs for OPPS payment.

NEW/REVISED:
EFFECTIVE DATE: JANUARY 1, 2007
IMPLEMENTATION DATE: JANUARY 2, 2007

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	4/Table of Contents
N	4/10/10.13/Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS
N	4/10/10.13.1/Requirement to Calculate CCRs for Hospitals Paid Under OPPS and for CMHCs
N	4/10/10.13.2/Circumstances in Which CCRs are Used

N	4/10/10.13.3/Selection of the CCR to be Used
N	4/10/10.13.4/Mergers, Acquisitions, and Other Ownership Changes
N	4/10/10.13.5/New Providers and Providers with Cost Report Periods Less Than a Full Year
N	4/10/10.13.6/Substitution of Statewide CCRs for Extreme OPPS Hospital Specific CCRs
N	4/10/10.13.7/Methodology for Calculation of Hospital Overall CCR for Hospitals that Do not Have Nursing and Paramedical Education Programs
N	4/10/10.13.8/Methodology for Calculation of Hospital Overall CCR for Hospitals that Have Nursing and Paramedical Education Programs
N	4/10/10.13.9/Methodology for Calculation of CCR for CMHCs
N	4/10/10.13.10/Location of Statewide CCRs, Tolerances for Use of Statewide CCRs in Lieu of Calculated CCRs and Cost Centers to be Used in the Calculation of CCRs
N	4/10/10.13.11/Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs
R	4/50/Outpatient PRICER
R	4/50/50.1/Outpatient Provider Specific File
R	4/70/Transitional Corridor Payments

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment – Business Requirements

This instruction is being re-communicated. The attached instruction was previously communicated as Sensitive, dated August 11, 2006. The attached instruction is no longer sensitive. The Transmittal Number, Issue Date and all other information remain the same.

Pub. 100-04	Transmittal: 1030	Date: August 11, 2006	Change Request 5238

SUBJECT: Policy Changes to the Fiscal Intermediary (FI) Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost to Charge Ratios (CCRs)

I. GENERAL INFORMATION

A. Background: Effective for services furnished on or after January 1, 2007, we have changed the methodology for calculating the overall CCR for hospitals paid under OPPS which have nursing and allied health education programs. The calculation of the overall OPPS CCR that the FIs have used since issuance of Change Request (CR) 2197, Transmittal A-03-004, issued January 17, 2003, to determine outlier payment and payment for services paid at charges reduced to cost includes payments for paramedical education and allied health costs. These costs are excluded from OPPS and paid through cost report settlement. They cannot be included in calculating CCRs for OPPS payment.

The previous instructions to FIs regarding calculation, use, and reporting of these CCRs that were issued in CR 2197 were never manualized. This CR: 1) changes the method for calculating the OPPS overall CCR for those hospitals that have nursing and paramedical education programs (about 700 hospitals); 2) changes the criteria for using Statewide CCRs in place of hospital specific CCRs; and 3) manualizes the longstanding instructions for calculating, using and reporting overall CCRs for hospitals paid under OPPS and for CMHCs that continue to be applicable.

B. Policy: The FIs must calculate overall cost to charge ratios for hospitals paid under OPPS and for CMHCs using the provider's most recent full year cost reporting period, whether tentatively settled or final settled, in accordance with the instructions in the Medicare Claims Processing Manual, Chapter 4, §10.13. The FI must calculate a provider overall CCR whenever a more recent full year cost report becomes available. If a CCR is calculated based on the tentatively settled cost report, the FI must calculate another overall CCR when the cost report is final settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever occurs first. If a CCR is based on a final settled cost report, the FI must calculate the CCR when a cost report for a subsequent cost reporting period is tentatively settled. The FI must report the CCRs calculated pursuant to these instructions within 30 days of the date they are calculated, and must report the CCRs in accordance with the manual instructions described above.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5238.1	Fiscal intermediaries shall calculate hospital outpatient cost to charge ratios (CCRs) and community mental health center (CMHC) CCRs in accordance with the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §10.13.	X								
5238.2	Fiscal intermediaries shall default to Statewide CCRs in circumstances described in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §10.13.	X								
5238.3	Fiscal intermediaries shall apply the most recently calculated hospital outpatient CCR or CMHC CCR or the selected Statewide CCR (where the Statewide CCR is selected) to charges for purposes of determining hospital OPPS or CMHC outlier payments, transitional outpatient PPS payments (TOPS), and pass through device payments.	X								
5238.4	Fiscal intermediaries shall report outpatient hospital and community mental health center (CMHC) CCRs or the Statewide CCR (where the Statewide CCR is selected) to the Outpatient Provider Specific File (OPSF) within 30 days of calculation of the CCR.	X								
5238.5	Fiscal intermediaries shall create a new provider record in the OPSF, along with a new effective date, when a more recent CCR is determined.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007	**No additional funding will be provided by CMS; contractor**

Implementation Date: January 2, 2007 **Pre-Implementation Contact(s):** Anita Heygster 410-786-4486 **Post-Implementation Contact(s):** Regional Office	**activities are to be carried out within their FY 2007 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.1030, 08-11-06)

10.13 - Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

10.13.1 - Requirement to Calculate CCRs for Hospitals Paid under OPPS and for CMHCs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

Fiscal Intermediaries (FIs) must calculate overall cost to charge ratios for hospitals paid under OPPS and for CMHCs using the provider's most recent full year cost reporting period, whether tentatively settled or final settled, in accordance with the instructions in §10.13.7, §10.13.8 or §10.13.9 as applicable. The FIs must calculate a provider overall CCR whenever a more recent full year cost report becomes available. If a CCR is calculated based on the tentatively settled cost report, the FI must calculate another overall CCR when the cost report is final or when a cost report for a subsequent cost reporting period is tentatively settled, whichever occurs first. If a CCR is based on a final settled cost report, the FI must calculate the CCR when a cost report for a subsequent cost reporting period is tentatively settled.

10.13.2 - Circumstances in Which CCRs are Used

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The FIs must apply CCRs prospectively to calculate outlier payments (for hospitals paid under OPPS and CMHCs), Transitional Outpatient Payment System (TOPS) payments (for hospitals paid under OPPS), and device pass through payments (for hospitals paid under OPPS).

10.13.3 - Selection of the CCR to be Used

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

FIs will use the CCR calculated for the most recent period of time, whether based on a tentatively settled cost report or a final settled cost report. For example, if the CCR being used is the tentatively settled CCR for FY 2007, and a tentatively settled CCR for FY 2008 is determined before the final settled CCR for FY 2007, then the FI will use the CCR based on the tentatively settled 2008 cost report.

10.13.4 - Mergers, Acquisitions, and Other Ownership Changes

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The FIs will use the CCR for the surviving provider in cases of provider merger, acquisition or other such changes.

Effective for hospitals experiencing a change of ownership after January 1, 2007, that have not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18, and do not yet have a Medicare cost report, the FI should use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report. For hospitals experiencing a change of ownership prior to January 1, 2007, the FI should use the prior hospital's cost to charge ratio.

10.13.5 - New Providers and Providers with Cost Report Periods Less than a Full Year

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The FIs must calculate a hospital CCR using the most recent full-year cost report if a hospital or CMHC has a short period cost report.

The FIs must use the Statewide CCR for all inclusive rate hospitals paid under OPPS, or when a new provider does not have a full year's cost report and has no cost report history.

See §10.13.10 for the location of the Statewide CCRs.

10.13.6 - Substitution of Statewide CCRs for Extreme OPPS Hospital Specific CCR

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The FIs must use the applicable Statewide average urban or rural hospital default ratio if the CCR calculated for a hospital paid under OPPS is greater than the upper limit CCR in the file of overall OPPS hospital CCR limits on the CMS Web site.

If the CCR for a hospital paid under OPPS is below the lower limit CCR in the file of overall OPPS hospital CCR limits, FIs must recheck the calculation to ensure that the CCR is, in fact, a valid CCR for the provider before entering the CCR into the OPSF. The FIs must use the CCR they calculate; they may not use the Statewide average urban or rural hospital as the default ratio in such a circumstance.

See §10.13.10 for the location of the Statewide CCRs and the upper limit above which the FI must use the Statewide CCR.

10.13.7 - Methodology for Calculation of Hospital Overall CCR for Hospitals that Do Not Have Nursing and Paramedical Education Programs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

In calculating the hospital's costs or charges, do not include departmental CCRs and charges for services that are not paid under the OPPS such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.

See §10.13.10 for the location of the list of exact cost centers that shall be included in the calculation of the overall CCR.

***Step 1 – Determining Overall Costs**: Calculate costs for each cost center by multiplying the departmental CCR for each cost center (and subscripts thereof) that reflect services subject to the OPPS from form CMS 2552-96, Worksheet C, Part I, Column 9 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D, Part V, Columns 2, 3, 4, and 5 (and subscripts thereof). Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.*

***Step 2 – Determining Overall Charges**: Calculate charges by summing the Medicare outpatient charges from form CMS 2552-96, Worksheet D, Part V, Columns 2, 3, 4, and 5 (and subscripts thereof) for each cost center (and subscripts thereof) that reflect services subject to the OPPS.*

***Step 3 – Calculating the Overall CCR**: Divide the costs from Step 1 by the charges from Step 2 to calculate the hospital's Medicare outpatient CCR.*

10.13.8 - Methodology for Calculation of Hospital Overall CCR for Hospitals that Have Nursing and Paramedical Education Programs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

Do not include departmental CCRs and charges for services not subject to the OPPS (such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.) in calculating the hospital's costs or charges.

See §10.13.10 for the location of the list of the exact cost centers that should be included in the overall CCR.

***Step 1 -- Determining costs for each department**: From Worksheet B, Part 1 – Column 27, deduct the nursing and paramedical education costs found on the applicable line in Columns 21, and 24 of Worksheet B, Part I to calculate a cost for each cost center.*

***Step 2 – Determining charges for each department**: From worksheet C, Part 1 – Column 8 (sum of columns 6 and 7), identify "total charges."*

***Step 3 – Determining the CCRs for each department without nursing and paramedical education costs**: For each line, divide the costs from Step1 by the charges from Step 2 to*

acquire CCRs for each line, without inclusion of nursing and paramedical education costs.

***Step 4 – Determining Overall Costs**:* *Multiply the CCR in step 3 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D Part V, Columns 2, 3, 4, and 5 (and subscripts thereof). Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.*

***Step 5 – Determining Overall Charges**:* *Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-96, Worksheet D, Part V, Columns 2, 3, 4, and 5 (and subscripts thereof) for each cost center (and subscripts thereof) that reflect service subject to the OPPS.*

***Step 6 – Calculating the Overall CCR**:* *Divide the costs from Step 4 by the charges from step 5 to calculate the hospital's Medicare outpatient CCR.*

10.13.9 - Methodology for Calculation of CCR for CMHCs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

Calculate the CMHC's CCR using the provider's most recent full year cost report, Form CMS 2088-92, and Medicare cost and charges form Worksheet C, Page 2. Divide costs from line 39.01, Column 3 by charges from line 39.02, Column 3 to calculate the CCR.

If the CCR is above 1.0 enter the appropriate Statewide average urban or rural hospital default ratio that is in the OPSF for the CMHC. There is no lower limit for CMHC CCRs. Use the CCR you calculate and do not substitute the Statewide average urban or rural hospital default ratio in cases where the CCR is below 1.0.

Note that CCR reporting requirements in §10.13 apply to both hospitals paid under OPPS and to CMHCs.

10.13.10 - Location of Statewide CCRs, Tolerances for Use of Statewide CCRs in Lieu of Calculated CCRs and Cost Centers to be Used in the Calculation of CCRs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The file of OPPS hospital upper and lower limit CCRs and the file of Statewide CCRs is located on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under the supporting documentation for the OPPS final rule. A spreadsheet listing the Statewide CCRs can be found in the file containing the preamble tables that appears in the final rule. The FIs must always use the most recent Statewide CCR.

The file of standard and nonstandard cost centers to be used in the calculation of hospital outpatient CCRs is also found on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/.

10.13.11 - Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The FIs shall report the OPPS hospital overall or CMHC CCR they calculate, or the Statewide CCR they select, for each provider to the Outpatient Provider Specific File (OPSF; see§50.1 of this Chapter) within 30 days after the date of the calculation or selection of the Statewide CCR for the provider. If a cost report reopening results in adjustments that would change the CCR that is currently in effect, the FI shall calculate and enter the CCR in the OPSF within 30 days of the date that the reopening is finalized. In such an instance, FIs must create an additional record in the OPSF for the provider. The FI entries in the OPSF shall include the effective date of the CCR being entered. Entries in the OPSF shall not replace a pre-existing entry for the provider.

50 - Outpatient PRICER

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

Outpatient *PRICER* determines the amount to pay as well as deductions for deductible and coinsurance.

This CMS developed software determines the APC line item price based on data from the FI's *Outpatient Provider Specific File (OPSF)*, the beneficiary deductible record and the OCE output file. *PRICER* will prepare an output data record with the following information:

- All information passed from the OCE;
- The APC line item payment amount;
- The APC line item deductible;
- The APC line item coinsurance amount;
- The total cash deductible applied to the OPPS services on the claim;
- The total blood deductible applied to the OPPS services on the claim;
- The APC line item blood deductible;
- The total outlier amount for the claim to be paid in addition to the line item APC payments. This amount is to be reported to CWF via value code 17 as is the process for inpatient outlier payments; and
- A *PRICER* assigned review code to indicate why or how *PRICER* rejected or paid the claim.

The *PRICER* implementation guide has information concerning *PRICER* processing reports, input parameters, and data requirements.

50.1 - Outpatient Provider Specific File

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The *Outpatient Provider Specific File (OPSF)* contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and *formats* are shown below. FIs must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

FIs must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the 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.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The created/run date of the PROV report for submittal to CO.

41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) N = not waived (provider is under OPPS)
50-54	9(5)	Intermediary Number	Enter the Intermediary #.
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, FIs will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990.

			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). 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 Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration 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
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. Does not apply to ESRD Facilities.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	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 wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.

71-72	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. FIs shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs
74-75	X(2)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. *See §10.13 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio.* Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location 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.

85-89	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 Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	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 equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate 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
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

The FI enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced

		coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

70 - Transitional Corridor Payments

(Rev.1030, Issued: 08-11-06, Effective: 01-01-07, Implementation: 01-02-07)

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) established transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals and permanent for children's hospitals effective August 1, 2000.

Section 405 of BIPA provides that children's hospitals described in §1886(d)(1)(B)(iii) will be held harmless permanently for purposes of calculating TOP amounts. This means that children's hospitals that are excluded from the inpatient hospital prospective payment system will receive the same transitional corridor hold-harmless protection as cancer hospitals under the OPPS. This provision is effective retroactively to August 1, 2000. FIs follow the TOP calculation steps described below and determine the TOP amount the children's hospital should have received retroactively to August 1, 2000. FIs compare the newly calculated amount to the interim TOP amounts that were already made to the hospital and make a lump sum payment for any additional estimated amounts due to the hospital. Future monthly TOPs calculations to these hospitals are described in the steps listed below. Note steps for TOP calculations prior to 2002 and revised calculations beginning calendar year 2002.

Beginning September 1, 2000, and every month thereafter until further notice, the shared system maintainers must provide FIs with software that gathers all data required to calculate a TOP amount for each hospital and CMHC. The software must calculate and pay the TOP amount for OPPS services on claims processed during the preceding month, maintain an audit trail (including the ability to generate a hardcopy report) of these TOP amounts, and transfer to the PS&R system any necessary data. TOP amounts should be paid before the next month begins and they are not subject to normal payment floor requirements.

Eight items contained in the provider file and defined under the *Outpatient Provider Specific File (OPSF)* section above are needed to calculate the TOP amount for each hospital or CMHC. They are:

- The provider number;
- Fiscal year begin date;
- The provider type;
- Change code for wage index reclassification;
- Actual geographic location - MSA;
- Wage index location - MSA;
- Bed size; and
- Outpatient cost to charge ratio.

Pursuant to §403 of BIPA, a TOP may be made to hospitals and community mental health centers (CMHCs) that did not file a cost report for the cost reporting period ending in calendar year 1996. The law was amended to provide that if a hospital did not file a

cost report for a cost reporting period ending in calendar year 1996, the payment-to-cost ratio used in calculating a TOP will be based on the hospital's first cost report for a period ending after calendar year 1996 and before calendar year 2001. This provision is effective retroactively to August 1, 2000.

Calculate interim TOP amounts for hospitals and CMHCs that did not have a cost report ending in calendar year 1996, but do have a cost report for a later period that ends prior to calendar year 2001 retroactively to August 1, 2000. FIs make a lump sum payment for any estimated amounts due the provider for prior months retroactive to August 1, 2000, and continue monthly payments as necessary for future months.

One additional item will be output from the *PRICER* software in 9(7)V99 format. It is the outlier payment amount. The shared system will sum the following items for use in steps 1 and 2 below:

- Total charges for all covered OPPS services on the claim;
- Total OPPS Medicare program payments on the claim; and,
- Total unreduced OPPS coinsurance on the claim and total OPPS deductible on the claim.