CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 693

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: SEPTEMBER 30, 2005

Change Request 4099

SUBJECT: Updates to the IRF and SNF Provider Specific File and Changes in Inpatient Rehabilitation Facility Prospective Payment System For FY 2006

I. SUMMARY OF CHANGES: CMS made several refinements to the inpatient rehabilitation facility prospective payment system (IRF PPS) in the FY 2006 IRF PPS Final Rule. These manual changes are based on the policies stipulated in the final rule. For example, the IRF PPS is transitioning from metropolitan statistical areas (MSAs) to Core Based Statistical Areas (CBSAs). Additionally, CMS established a hold harmless policy to prevent significant losses to certain providers. There are also low-income percentage (LIP), rural, and outlier percentage changes which will effect the Pricer.

NEW/REVISED MATERIAL

EFFECTIVE DATE: Discharges on or after October 1, 2005

IMPLEMENTATION DATE: October 31, 2005

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/20/2.3.1/Provider-Specific File
R	3/140/ 2.2/Case-Mix Groups
R	3/140/2.4 /Facility Level Adjustments
R	3/140/2.4.1/Area Wage Adjustment
N	3/140/2.4.2/Rural Adjustment
N	3/140/2.4.4/Outlier
N	3/140/2.4.5/Teaching Status Adjustment

N	3/140/2.4.5.1/ FTE Resident Cap
R	3/140/3.2/IRF PPS Pricer Software
R	3/Addendum A – Provider Specific File

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 693	Date: September 30, 2005	Change Request 4099

SUBJECT: Updates to the Providers Specific File and Changes in Inpatient Rehabilitation Facility Prospective Payment System for FY 2006

I. GENERAL INFORMATION

CMS has made several refinements to inpatient rehabilitation facility prospective payment system (IRF PPS) in the FY 2006 IRF PPS Final Rule. This CR will manualize those changes.

A. Background: CMS made several refinements to the inpatient rehabilitation facility prospective payment system (IRF PPS) in the FY 2006 IRF PPS Final Rule. These manual changes are based on the policies stipulated in the final rule. For example, the IRF PPS is transitioning from metropolitan statistical areas (MSAs) to Core Based Statistical Areas (CBSAs). Additionally, CMS established a hold harmless policy to prevent significant losses to certain providers. There are also low-income percentage (LIP), rural, and outlier percentage changes which will affect the Pricer.

B. Policy: Section 1886(j)(5) of the Act requires the Secretary of Health and Human Services (the Secretary) to publish in the Federal Register on or before August 1 before each fiscal year, the classification and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year. These updates to the manual are being done in order to conform the manual to any changes specified in the most recent IRF PPS final rule, or to clarify existing sections of the manual.

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	
4099.1	Contractors shall be in compliance with the instructions in Pub 100-04, Chapter 3, Section 20 Subsection 2.3, and Section 140, subsections 2.2, 2.4, 2.4.1, 2.4.2, 2.4.4, 2.4.5, 2.4.5.1, and 3.2.	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	
4099.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								

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*: October 1, 2005 **Implementation Date:** October 31, 2005 **Pre-Implementation Contact(s):** August Nemec (410) 786-0612 **Post-Implementation Contact(s):** August Nemec (410) 786-0612	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 693, 09-30-05)

20.2.3.1 - Provider-Specific File

(Rev. 693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the FI makes an additional record showing the effective date of the change.
The format and data required by the PRICER program and by the provider-specific file is found in Addendum A.

The FIs submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), SNFs, and hospices, including those in Maryland. Regional home health FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

The FIs create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

NOTE: FIs submit the latest available provider-specific data for the entire reporting period to CO by the seven-business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the FI may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A. PPS Hospitals

The FIs submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

B. Non-PPS Hospitals and Exempt Units

The FIs create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

C. Hospice

The FIs create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all hospices. Data elements 33 and 38 are optional and may be populated if needed.

D. Skilled Nursing Facility (SNF)

The FIs create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998.

The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required. Data element 35 is required for all SNFs. Data elements 33 and 38 are required if there is a special wage index. Effective October 1, 2005, through September 30, 2006, data elements 33 and 38 are required since there is a special wage index.

E. Home Health Agency (HHA)

The FIs create a provider specific history file using the following data elements for each HHA. Regional home health FIs (RHHIs) submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

F. Inpatient Rehabilitation Facilities (IRFs)

The FIs create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type

Effective October 1, 2005, data element 13 is no longer applicable to payment applications but is still required . Data element 35 is required for all IRFs. Data elements 18, 33, 38, and 49 are required if applicable to the IRF.

G. Long Term Care Hospital (LTCH)

The FIs create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Effective July 1, 2005, data element 35 is required. Data elements 33 and 38 are optional and may be populated if needed. Data elements 12, 13, and 14 are no longer applicable.

H. Inpatient Psychiatric Facilities (IPF)

The FIs create a provider specific history file using the following data elements for each IPF beginning with their first cost reporting period that starts on or after January 1, 2005.

The FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 1, 3, 4, 5, 6, 7, 8, 10, 13, 18, 19, 21, 22, 23, 25,33, 35, 38, and 48 are required. All other data elements are optional for this provider type. Although data element 25 refers to the operating cost to charge ratio, ensure that both operating and capital cost-to-charge ratio are entered in data element 25 for IPFs. Ensure that data element 21 (Facility Specific Rate) will be determined using the same methodology to determine the interim payment per discharge under the TEFRA system.

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

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. FIs must set up an NDM transfer from the FI's system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center

using the following input data set names ("99999" should be changed to the FI's 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999
DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)
Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See ***Addendum A*** for the Provider Specific File record layout and description.

140.2.2 - Case-Mix Groups

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities were used to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are *codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous.* In addition to the *first two digits of the CMG indicating what is the RIC*, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age improves the explanatory power of the CMGs if some groups are split based on this variable. Lastly, comorbidites were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

140.2.4 - Facility Level Adjustments

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facility's located in rural areas, an adjustment for treating low-income patients *and an adjustment for teaching facilities*. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can be determined to qualify for these additional payments only after all other facility-level adjustments are computed. Thus, for ease of understanding, the discussion of these facility-level and outlier adjustments are presented in the same order that is used to assess their applicability.

140.2.4.1 - Area Wage Adjustments

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

To adjust payments for area wage differences, CMS first identifies the labor-related portion of the prospective payment rates *which is published annually in the* ***Federal Register***. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. *CMS uses the inpatient acute care hospital wage data to compute the wage indices on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassification under §§1886(d)(8) or (d)(10) of the Act and without applying the "rural floor" under §4410 of the BBA.* The wage data excludes the wages for services provided by teaching

physicians, interns and residents, and nonphysician anesthetists under Medicare part B, because these services are not covered under the IRF PPS. The wage index that applies to the IRF PPS payment rates excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists. *For IRF PPS discharges occurring before October 1, 2005,* IRFs are divided into labor market areas where urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget.

For IRF PPS discharges occurring on or after October 1, 2005, the IRF PPS adopts new labor market area definitions based upon the new statistical area definitions issued by the Office of Management and Budget (OMB) in OMB Bulletin No. 03-04, June 6, 2003. OMB Bulletin No. 03-04 includes new definitions of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, more commonly referred to as Core-Based Statistical Areas (CBSAs). CBSA-based designations reflect the most recent available geographic classifications and more accurately reflect current labor markets. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs. CMS uses the county-based areas for all MSAs in the Nation, including those in New England. Adopting county-based labor market areas for the entire country creates consistency and stability in the Medicare payment program because all of the labor market areas, including New England, are defined using the same system (that is, counties), rather than different systems in different areas of the country, and minimizes program complexity. CMS uses the Metropolitan Divisions where applicable under the new CBSA-based labor market area definitions to determine urban areas. Micropolitan Areas are treated as rural labor market areas under the IRF PPS. To calculate the statewide rural wage index for each State, CMS combines all of the counties in a State outside of a designated urban area, including Micropolitan Areas. The rural and Micropolitan IRFs are assigned a statewide rural wage index for the state in which the IRF is located. The wage indices applicable to IRF PPS discharges occurring on or after October 1, 2005, are published in the annually in the ***Federal Register****.*

A one-year transition policy providing for a blended wage index (50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index that are both based on the FY 2001 hospital wage data) will apply to all IRFs. This transition policy is effective for discharges occurring on or after October 1, 2005 and on or before September 30, 2006. The transition will mitigate the negative impact for IRFs that experience a decrease in the wage index and allow one year for all IRFs to transition from the MSA-based wage index to the CBSA-based wage index.

140.2.4.2 - Rural Adjustment

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-MSA area.

For FY 2006 and FY 2007, a hold harmless policy applies to IRFs that meet the definition of rural in FY 2005 in § 412.602 and become urban under the FY 2006 CBSA-based designations. The IRFs that meet the criteria described in the previous sentence will qualify for an adjustment to their payments in FY 2006 and FY 2007 equal to some portion of the 19.14 percent rural adjustment effective in FY 2005. This adjustment is in addition to the one-year blended wage index described above for discharges occurring on or after October 1, 2005 and on or before September 30, 2006.

140.2.4.4 - Outliers

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

Additional payments are made for any discharge if the estimated cost of a case exceeds the adjusted IRF PPS payment for the CMG plus the adjusted threshold amount. The estimated cost of the case is calculated by multiplying the IRF's overall cost-to-charge ratio (CCR), obtained from the latest settled cost report (subject to a ceiling), by the Medicare allowable covered charge. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments are added to the adjusted payment amount. The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above). *The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the Federal Register.*

A national CCR based on the facility location of either rural or urban is applied in the following situations:

- *New IRFs that have not yet submitted their first Medicare cost report.*
- *IRFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean.*
- *Other IRFs for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital CCR (or both) are not available.*

For new facilities, the national ratio will be used until the IRF's actual CCR can be computed using the first tentative settled or final settled cost report data , which will then be used for the subsequent cost report periods. The national urban and rural CCRs for IRFs are set forth annually in the Federal Register.

140.2.4.5 - Teaching Status Adjustment

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The teaching status adjustment is a facility level adjustment made to the Federal per discharge base rate to account for the higher indirect operating costs experienced by facilities that participate in graduate medical education. The adjustment is made on a

claim basis as an interim payment, with final payment in full for the cost reporting period made through the cost report. Any difference between the interim payments and the actual teaching status adjustment amount computed in the cost report are adjusted through lump sum payments/recoupments when the cost report is filed and later settled. The adjustment is based on the IRF's "teaching variable," which is the ratio of the number of FTE residents training in the IRF (subject to the FTE resident cap described below) to the IRF's average daily census (ADC). .

140.2.4.5.1 - FTE Resident Cap

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment, not the number of residents teaching institutions can hire or train. The FTE resident cap is identical in freestanding teaching rehabilitation hospitals and in distinct part rehabilitation units with GME programs. The cap is the number of FTE residents that trained in the IRF during a "base year."

An IRF's FTE resident cap is determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. IRFs that first began training residents after November 15, 2004 will initially receive an FTE cap of zero. The FTE caps for new IRFs (as well as existing IRFs) that start training residents in a new GME program (as defined in § 413.79(1)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in § 412.424(d)(1)(iii)(B)(2)), which in turn are made in accordance with the policies described in 42 CFR 413.79(e).

IRFs are not permitted to aggregate the FTE resident caps used to compute the IRF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents floating through the rehabilitation hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IRF (for example, a resident on a full-time, 3-month rotation to the IRF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPPS IME adjustment is allowed to be counted for purposes of the teaching status adjustment for the IRF PPS.

The denominator used to calculate the teaching status adjustment under the IRF PPS is the IRF's average daily census (ADC) from the current cost reporting period. If a rehabilitation hospital or unit has more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If a rehabilitation hospital or unit were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility hires and trains).

140.3.2 - IRF PPS Pricer Software

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

The CMS has developed an IRF Pricer Program that calculates the Medicare payment rate. Pricer will use a variety of inputs listed below to calculate the payment rate.

A. Inputs to Pricer

- Provider Specific File data *(see section 20.2.3.1 and Addendum of this chapter for required elements)*
- Bill Data includes:
  - Provider number:
  - Patient Status:
  - Payment Modification Flag (if condition code is 66, set flag "Y" otherwise use "N.");
  - Covered Charges;
  - Discharge Date;
  - HIPPS/CMG Rate Code;
  - Length of Stay (LOS);
  - Covered Days;
  - Lifetime Reserve Days (LTR)

B. Data Returned From Pricer

Pricer returns the following information:

- PPS Return Code
- MSA */CBSA (effective October 1, 2005)*
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-Income Payment (LIP) Amount
- *Teaching Amount (effective October 1, 2005)*
- LOS
- Regular Days Used

- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

The Pricer is available electronically to the Shared Systems.

Addendum A - Provider Specific File

(Rev.693, Issued: 09-30-05, Effective: 10-01-05, Implementation: 10-31-05)

A-03-058 (for CCR development)

Data Element	File Position	Format	Title	Description
1	1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character Identifier (NPI) Provider number.
2	9-10	X(2)	NPI Filler	Blank.

Data Element	File Position	Format	Title	Description
3	11-16	X(6)	Provider Oscar No.	Alphanumeric 6 character provider number. Cross check to Item 10, provider type. Positions 3 and 4 of:

Provider #	Type (see field 10)
00-08	Blanks, 00, 07-11, 13-17, 21-22
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Codes for special units M, R, S, T, U, V, W, U and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).

4	17-24	9(8)	Effective Date	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. Month 01-12, day 01-31, year greater than 82 but not greater than current year.

Data Element	File Position	Format	Title	Description
5	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD Day: 01-31, Month: 01-12 Year: Greater than 81, but not greater than current year. 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 (Field #4 above).
6	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
7	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting FI 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 FI, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing FI. Likewise, if the provider identification number changes, the FI must place a termination date in the PROV file transmitted to CO for the old provider identification number.
8	49	X	Waiver Indicator	Provider waived from PPS? Must be Y

Data Element	File Position	Format	Title	Description
				(yes) or N (no). Y = means waived (Provider is not under PPS). N = means not waived (Provider is under PPS).
9	50-54	9(5)	Intermediary Number	Assigned intermediary number.
10	55-56	X(2)	Provider Type	This identifies providers that require special handling. The FI enters the appropriate code: Must be blank or 00, 02-08, 13-18, 21-23, or 32-38. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility

Data Element	File Position	Format	Title	Description	
				14	Medicare Dependent Hospital (During cost reporting periods that began on or after 4-1-90.)
				15	Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after 4-1-90. Invalid 10/1/94 through 90-30-97. See §20.6B.)
				16	Rebased Sole Community Hospital
				17	Rebased Sole Community Hospital/Referral Center
				18	Medical Assistance Facility
				21	Essential Access Community Hospital (EACH)
				22	Essential Access Community Hospital/Referral Center
				23	Rural Primary Care Hospital
				32	Nursing Home Case Mix Quality Demonstration Project - Phase II (SNF only)
				33	Nursing Home Case Mix Quality Demonstration Project - Phase III Step 1 (SNF only)
				34	Reserved

Data Element	File Position	Format	Title	Description	
				35	Hospice
				36	Home Health Agency
				37	Critical Access Hospital
				38	Skilled Nursing Facility (SNF) - For Non demo PPS SNF's - eff. for cost reporting periods beginning on or after 7/1/98.
11	57	9	Current Census Division	Must be numeric (1-9). The Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, FIs 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

Data Element	File Position	Format	Title	Description
	NOTE: When a facility is reclassified for purposes of the standard amount, the FI Changes the census division to reflect the new standardized amount location.			
12	58	X	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.
13	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.
14	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.
15	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

Data Element	File Position	Format	Title	Description
				actual location MSA if this field is left blank
16	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.
17	73	X	Change Code for 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.

Data Element	File Position	Format	Title	Description
				Leave blank for hospitals if there has not been a Lugar reclassification.
18	74	X	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 47780). The table can also be found at the following website: www.cms.hhs.gov/providers/irfpps/irfdata.asp.*
19	75	X	Federal PPS Blend Indicator	HHA: 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 All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. LTCH: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002.

Data Element	File Position	Format	Title	Description		
					Federal %	Facility%
				1	20	80
				2	40	60
				3	60	40
				4	80	20
				5	100	00
				IPF: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all IPF providers with cost reporting periods beginning on or after 1/1/2005.		
					Federal %	Facility%
				1	25	75
				2	50	50
				3	75	25
				4	100	00
20	76-89	X(5)	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.		

Data Element	File Position	Format	Title	Description
				For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91 92-96	9V9(3) 9V9(4)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.
23			Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The FI 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. *For IPFs, 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

Data Element	File Position	Format	Title	Description
				dividing the Medicare operating costs by the 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 FI billing file, i.e., PS&R record. For hospitals for which the FI 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, IPF and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments. Enter the Medicaid ratio used to determine if the hospital qualifies for a

Data Element	File Position	Format	Title	Description
				disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
28	115-118	V9(4)	Medicaid Ratio	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91
29	119	X	Provider PPS Period	
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	Code 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

Data Element	File Position	Format	Title	Description
34	139	X(1)	Hospital Quality Indicator	Code indicates hospital meets criteria to receive higher payment per MMA quality standards. 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

Data Element	File Position	Format	Title	Description
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) 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 field 33 = "1" or "2"
39	161-166	9(4) V99	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) V99	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.
				Per diem amount based on the interim payments to the hospital. Include standard

Data Element	File Position	Format	Title	Description
41	173-178	9(4) V99	Pass Through Amount for Organ Acquisition	acquisition amounts for kidney, heart, 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) V99	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.
				Type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate

Data Element	File Position	Format	Title	Description
				C = Fully prospective blended rate
			Capital PPS Payment Code	
43	185	X		
				Must be present unless a "Y" is entered in location 49 (position 207), or 08 is entered in location 55-56 or a termination date is present in location 41-48.
44	186-191	9(4) V99	Hospital Specific Capital Rate	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) V99	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	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the FI 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

Data Element	File Position	Format	Title	Description
				deviation band. The FI 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	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if the period is more than two years after the provider accepted its first patient.
49	208-212	9V9(4)	Capital Indirect Medical Education Ratio	Enter the ratio of residents/interns to the hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. (See §20.4.1 *for inpatient acute hospital and §140.2.4.3 and 140.2.4.5.1 for IRFs.)* Zero fill for a non-teaching hospital.
	213-218	9(4) V99	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
50	219-240	X (22)	Filler	Blank.
51				

Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and LTCH Prospective Payment Systems

Use of More Recent Data for Determining CCRs

A. Changing CCRs For Hospitals Subject to the IPPS

Under 42 CFR 412.84(i)(1), if more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate of increase among other hospitals), as explained below, CMS may direct the FI to change the hospital's operating and capital CCRs to reflect the high charge increases evidenced by the later data. A hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change.

FIs are to perform data analysis to identify those hospitals that appear to have disproportionately benefited from the time lag in updating the CCRs using the latest settled cost reports. These are hospitals:

1. With FY 2003 operating outlier payments of at least 10 percent of total operating diagnosis-related group (DRG) payments plus operating outlier payments;
2. Whose operating outlier payments relative to total operating DRG payments increased by at least 20 percent from either FY 2001 to FY 2002, or FY 2002 to FY 2003; and
3. Whose average charges per case increased by at least 15 percent both from FY 2000 to FY 2001, and from FY 2001 to FY 2002.

FIs are also to perform data analysis to identify hospitals that received operating outlier payments in excess of 100 percent of total operating DRG payments for FY 2003 (outlier payments divided by DRG payments).

Effective for discharges occurring on or after August 8, 2003, for hospitals that are identified through the above data analysis, FIs are to use an alternative CCR rather than one based on the latest settled cost report (such as a CCR based on data from the latest tentative settled cost report or more recent data) to identify and pay for outliers under the IPPS. By July 25, 2003, for each of the hospitals identified, FIs should calculate a capital and operating CCR using the alternative data and submit this ratio to CMS (to the attention of Michael Treitel, e-mail at mtreitel@cms.hhs.gov). CMS will notify FIs whether to use these ratios or an alternative ratio. For all IPPS claims processed on or after August 8, 2003, until more accurate data becomes available, FIs are to use this approved alternative ratio.

B. Use of Alternative Data in Determining CCRs For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

Under 42 CFR 412.84(i)(1) of the IPPS and 42 CFR 412.525(a)(4)(ii), 42 CFR 412.529(c)(5)(ii) of the LTCH PPS, CMS may direct FIs to use an alternative CCR to the CCRs from the later of the latest settled cost report or latest tentative settled cost report), if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled

cost report would not result in the most accurate CCR, then the FI should contact CMS to seek approval to use a CCR based on alternative data.

Also, a hospital may request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the hospital.

C. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For discharges beginning on or after October 1, 2003, FIs use CCRs from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs. By October 1, 2003, for all hospitals that are paid under the IPPS or LTCH PPS, FIs must have updated CCRs on the Provider Specific File (PSF) to reflect CCRs from the most recent tentative settlements or final settled cost reports, (whichever is the later period). These updated CCRs are used to process claims with discharge dates on or after October 1, 2003. The CCR on the PSF must be updated when that cost report is settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever is the latest cost reporting period.

In order to arrive at CCRs to be used in the PSF based on tentative settlement data, the FI should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCRs to determine if they had an impact on the CCRs. If these tentative settlement adjustments have no impact on the CCRs, or if no adjustments were made, the tentative settled CCRs will equal the CCRs from the hospital's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCRs, the FI should compute new CCRs based on the tentative settlement. (Note: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20 percent or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of CCRs for all hospitals for discharges on or after October 1, 2003, FIs should continue to update a hospital's operating and capital CCRs each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. Revised CCRs will be applied prospectively to all IPPS and LTCH PPS claims processed after the update.

II. Statewide Average for Hospitals Subject to the IPPS and for Hospitals Subject to the LTCH PPS

Prior to August 8, 2003, hospitals were assigned a statewide average CCR if their actual operating or capital CCR fell outside 3 standard deviations from the respective national geometric mean CCR.

Effective August 8, 2003, a hospital is longer be assigned the statewide average CCR when the hospital has a CCR that falls below 3 standard deviations from the national mean. Hospitals receive their actual CCRs, no matter how low their ratios fall.

The statewide average CCRs may still apply in those instances in which a hospital's operating or capital CCRs exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report may still receive the statewide average CCRs. CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the statewide CCRs applicable to IPPS hospitals and LTCHs in each year's annual notice of prospective payment rates published in the "Federal Register."

III. Reconciling Outlier Payments For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For the hospitals under the IPPS for which the FI applied alternative CCRs for discharges occurring on or after August 8, 2003 (that were identified through the above 3-step data analysis), and, for discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, FIs reconcile outlier payments at the time of cost report final settlement if:

1. Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
2. Total outlier payments in that cost reporting period exceed $500,000.

Consistent with the June 9, 2003 Federal Register (68 FR 34504) in which CMS indicated that it intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow FIs to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs. Similarly, for hospitals subject to the LTCH PPS, for discharges occurring in cost reporting periods beginning on or after October 1, 2003, reconciliation should be made if:

1. Actual operating CCRs are found to be plus or minus 10 percentage points from the CCRs used during that cost reporting period to make outlier payments, and
2. High cost outlier payments made under 412.525 and short stay outlier payments made under 42 CFR 412.529 combined exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which high cost outlier and/or short stay outlier payments were made in a cost reporting period.

If the above criteria for IPPS hospitals and LTCHs do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for

those hospitals are significantly inaccurate, FIs have the administrative discretion to reconcile cost reports of those additional IPPS hospitals and LTCHs. However, FIs must seek approval from their CMS Regional Office in the event they intend to reconcile outlier payments for an IPPS hospital or a LTCH that does not meet the above-specified criteria.

IV. Notification to Hospitals under the IPPS and the LTCH PPS

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