CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 707

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: OCTOBER 12, 2005

Change Request 3966

Transmittal 703 dated October 7, 2005, is rescinded and replaced with Transmittal 707, dated October 12, 2005 to indicate the November 7, 2005, effective date , which was not inserted in the Manual Instruction before release. All other information remains the same.

SUBJECT: IPPS Outlier Reconciliation

I. SUMMARY OF CHANGES: This transmittal tells FIs how to implement the policies of IPPS reconciliation and how to apply the time value of money to reconciliation. It also tells how to calculate cost-to-charge ratios and when to use alternative data for cost-to-charge ratios. Finally, it tells FIs which cost-to-charge ratio to apply in instances of hospital mergers and what to do when errors occur with cost-to-charge ratios and outlier payments.

NEW/REVISED MATERIAL
EFFECTIVE DATE: November 7, 2005
IMPLEMENTATION DATE: November 7, 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 – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/20.1.2/Outliers
N	3/20.1.2.1/Cost to Charge Ratios
N	3/20.1.2.2/Statewide Average Cost to Charge Ratios

N	3/20.1.2.4/Transfers
N	3/20.1.2.5/Reconciliation
N	3/20.1.2.6/Time Value of Money
N	3/20.1.2.7/Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments
N	3/20.1.2.8/Specific Outlier Payments for Burn Cases
N	3/20.1.2.9/QIO Reviews and Adjustments

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: 707	Date: October 12, 2005	Change Request 3966

Transmittal 703 dated October 7, 2005, is rescinded and replaced with Transmittal 707, dated October 12, 2005 to indicate the November 7, 2005, effective date , which was not inserted in the Manual Instruction before release. All other information remains the same.

SUBJECT: IPPS Outlier Reconciliation

I. GENERAL INFORMATION

A. Background:

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

Under 42 CFR § 412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the cost-to-charge ratio CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred.

In addition, under 42 CFR § 412.84(i)(4), effective for discharges occurring on or after August 8, 2003, at the time of reconciliation under paragraph (h)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

B. **Policy:** This transmittal tells FIs how to implement the policies of IPPS reconciliation and how to apply the time value of money to reconciliation. It also tells how to calculate cost-to-charge ratios and when to use alternative data for cost-to-charge ratios. Finally, it tells FIs which cost-to-charge ratio to apply in instances of hospital mergers and what to do when errors occur with cost-to-charge ratios and outlier payments.

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	
3966.1	For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 FIs shall use alternative CCRs rather than one based on the latest settled cost report when determining a hospital's CCR.	X								
3966.2	For those hospitals that did <u>not</u> meet the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective October 1, 2003, FIs shall 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.	X								
3966.2.1	FIs shall notify the CMS regional office and CMS Central Office to seek approval to use a CCR based on alternative data 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. [Note: The CMS regional office, in conjunction with the CMS Central Office, must approve the FI's request before the FI may use a CCR based on alternative data.]	X								
3966.3	Effective August 8, 2003, the FI shall notify the CMS regional office and CMS Central Office if a hospital requests that a different CCR be applied in the event it believes the CCR being applied is inaccurate. [Note: The CMS regional office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital for use of a different CCR.]	X								
3966.4	The FI shall notify a hospital whenever it makes a change to its CCR.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3966.5	When a CCR is changed as a result of a tentative settlement or a final settlement, FIs should include the change in the notice that is issued to each provider after a tentative or final settlement is completed. [Note: FIs can also send notification of a change to a hospital's CCR in a separate notice outside of the notice that is issued to each provider after a tentative or final settlement is completed.]	X								
3966.5.1	Effective 30 days from issuance, for hospitals that merge, FIs shall continue to use the operating and capital CCRs from the hospital with the surviving provider number.	X								
3966.6	Effective 30 days from issuance, if hospitals merge and a new provider number is issued, FIs shall use the Statewide average CCR because a new provider number indicates the creation of a new hospital. [Note: The policy of section 20.1.2.1 part C can be applied as an alternative to the Statewide average.]	X								
3966.6.1	FIs shall contact the CMS Central Office to seek further guidance in instances where errors related to CCRs and/or outlier payments are discovered.	X								
3966.6.2	If a cost report is reopened after final settlement, and the reopening affects the hospitals CCR or outlier payments, FIs shall contact and notify the CMS regional and Central Office for further instructions.	X								
3966.6.3.1	FIs shall reopen any cost report that has been final settled prior to the issuance of this manual revision that meets the qualifications for reconciliation.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3966.6.3.2	FIs shall issue a reopening notice to the provider and notify the CMS Central Office and regional office that the outlier payments need to be reconciled, using the procedures in 20.1.2.5	X								
3966.6.4	When reprocessing claims due to outlier reconciliation, FIs shall maintain an accurate history of certain fields within the provider specific file (PSF). As a result, the following fields in the PSF can only be altered on a prospective basis. These fields include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, Operating Cost to Charge Ratio, 27, SSI Ratio, 28, Medicaid Ratio, 47, Capital Cost to Charge Ratio 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary.	X								
3966.7	Effective for discharges on or after August 8, 2003, FIs shall use a Statewide average CCR only if it is unable to determine an accurate operating or capital CCR for a hospital in one of the following circumstances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18.) 2. Hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b) of the CFR. 3. Other hospitals for whom accurate data	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	with which to calculate either an operating or capital CCR (or both) are not available. [Note the policies of section 20.1.2.1 part C can be applied as an alternative to the Statewide average.]									
3966.8	FIs shall notify the CMS regional office and CMS Central Office of any hospital that meets the criteria for reconciliation.	X								
3966.9	To determine if a hospital meets the criteria of reconciliation, the FI shall perform the following steps: (1) incorporate all the adjustments from the cost report, (2) run the cost report, (3) calculate the revised CCR and (4) compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria is not met, the cost report can be finalized. If the criteria is met, FIs shall follow the instructions in this manual update. The NPR cannot be issued nor can the cost be finalized until outlier reconciliation is complete.	X								
3966.10	If it is determined that a hospital meets the criteria of reconciliation, the FI shall submit to the CMS Central Office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report.	X								
3966.10.1	The FI submits this data (preferably in electronic format) to the CMS Central Office via the addresses provided in section 20.1.2.1.b	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3966.10.2	The FI shall submit the following data fields: PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) and 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.	X								
3966.11	If a hospital's outlier claims are reconciled, the FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.	X								
3966.12	After reconciliation, the FI shall finalize the cost report, issue an NPR and make the necessary adjustment from or to the provider.	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	
3966.13	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:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 7, 2005	No additional funding will be

Implementation Date: November 7, 2005 **Pre-Implementation Contact(s):** Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov Miechal Lefkowitz 410-786-5316 miechal.lefkowitz@cms.hhs.gov **Post-Implementation Contact(s):** Michael Treitel 410-786-4552 michael.treitel@cms.hhs.gov Miechal Lefkowitz 410-786-5316 miechal.lefkowitz@cms.hhs.gov	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. 707, 10-12-05)

20.1.2 - Outliers

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an "Outlier" is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

The actual determination of whether a case qualifies for outlier payments is made by the fiscal intermediary (FI) using Pricer, which takes into account both operating and capital costs and diagnostic related group (DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs). Any outlier payment due is added to the DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp.

As discussed in greater detail in section 20.1.2.9, if the Quality Improvement Organization (QIO) determines the claim should be partially or completely denied, it informs the FI, which shall prepare an adjustment bill.

IPPS outliers are not applicable to non-PPS hospitals. The Pricer program makes all outlier determinations except for the medical review determination. Outlier payments apply only to the Federal portion of a capital PPS payment.

20.1.2.1 - Cost to Charge Ratios

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

A. Calculating a Cost-to-Charge Ratio

For IPPS outlier calculations, Medicare's portion of hospital costs are determined by using hospital specific cost-to-charge ratios (CCRs). At the end of the cost reporting period, the hospital prepares and submits a cost report to its FI, which includes Medicare allowable costs and charges. The FIs complete a preliminary review of the as-submitted cost report and issue a tentative settlement. The cost report is later final settled, which may be based on a subsequent review, and an NPR is issued.

The FI shall update the PSF using the CCR calculated from the final settled cost report or from the latest tentative settled cost report (whichever is from the later period).

Effective November 7, 2005, the following methodology shall be used to calculate a hospital's operating and capital CCRs.

Inpatient PPS Operating CCR

1) *Identify total Medicare inpatient operating costs from the Medicare cost report, from Worksheet D-1, Part II, line 53. (If a positive amount is reported on line 42 for nursery costs, subtract this amount on line 42 from the amount on line 53).*
2) *Identify total Medicare inpatient operating charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.*
3) *Determine the Inpatient PPS operating CCR by dividing the amount in step 1 by the amount in step 2.*

Inpatient Capital CCR

1) *Identify total Medicare inpatient capital cost from Worksheet D Part 1, column 10, sum of lines 25 through 30, plus column 12, sum of lines 25 through 30 plus Medicare inpatient ancillary capital costs from Worksheet D Part II, column 6, line 101 plus column 8 line 101 .*
2) *Identify total Medicare inpatient capital charges (the sum of routine and ancillary charges), from Worksheet D-4, column 2, the sum of lines 25 through 30 and line 103.*
3) *Determine the Inpatient PPS capital CCR by dividing the amount in step 1 by the amount in step 2.*

B. Use of Alternative Data in Determining CCRs For Hospitals and Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS

For discharges before August 8, 2003, FIs used the latest final settled cost report to determine a hospital's CCRs. For those hospitals that met the criteria in part I. A. of PM A-03-058 (July 3, 2003), effective for discharges occurring on or after August 8, 2003 FIs are to use alternative CCRs rather than one based on the latest settled cost report

when determining a hospital's CCR (to download PM A-03-058, visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp). For all other hospitals, effective October 1, 2003, FIs are to use CCRs from the latest final 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.

FIs shall continue to update a hospital's operating and capital CCRs each time a more recent cost report is settled (either final or tentative). Revised CCRs shall be entered into the Provider Specific File not later than 30 days after the date of the latest settlement used in calculating the CCRs.

Effective August 8, 2003, the CMS Central Office may direct FIs to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, 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 shall notify the CMS regional office and CMS Central Office to seek approval to use a CCR based on alternative data. For example, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs and/or charges. The CMS regional office, in conjunction with the CMS Central Office, must approve the FI's request before the FI may use a CCR based on alternative data. Revised CCRs will be applied prospectively to all IPPS claims processed after the update. FIs shall send notification to the CMS Central Office via the following address and email address:

CMS
C/O Division of Acute Care- IPPS Outlier Team
7500 Security Blvd
Mail Stop C4-08-06
Baltimore, MD 21244

outliersIPPS@cms.hhs.gov

C. Request by the Hospital for use of a Different CCR

Effective August 8, 2003, a hospital will have the opportunity to 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. After the FI has evaluated the evidence presented by the hospital, the FI notifies the CMS regional office and CMS Central Office of any such request. The CMS regional office, in conjunction with the CMS Central Office, will approve or deny any request by the hospital for use of a different CCR. FIs shall send requests to the CMS Central Office using the address and email address provided above.

D. Notification to Hospitals Under the IPPS of a Change in the CCR

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

E. Hospital Mergers and Errors with CCRs

Effective November 7, 2005, for hospitals that merge, FIs shall continue to use the operating and capital CCRs from the hospital with the surviving provider number. If a new provider number is issued, as explained in section 20.1.2.2 below, FIs use the Statewide average CCR because a new provider number indicates the creation of a new hospital (as stated in 42 CFR 412.84 (i)(3)(i), a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement). However, the policy of section 20.1.2.1 part C can be applied to determine an alternative to the Statewide average.

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

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

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

When reprocessing claims due to outlier reconciliation, FIs shall maintain an accurate history of certain fields in the provider specific file (PSF). This history is necessary to ensure that claims already processed (from prior cost reporting periods that have already been settled) will not be subject to a duplicate systems adjustment in the event that claims need to be reprocessed. As a result, the following fields in the PSF can only be altered on a prospective basis: -23 -Intern to Bed Ratio -24 --Bed Size -25 -Operating Cost to Charge Ratio -27 -SSI Ratio -28 -Medicaid Ratio -47 -Capital Cost to Charge Ratio 49 -Capital IME and 21 -Case Mix Adjusted Cost Per Discharge. A separate history outside of the PSF is not necessary.

20.1.2.2 - Statewide Average Cost-to-Charge Ratios

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

For discharges prior to August 8, 2003, Statewide average CCRs are used in those instances in which a hospital's operating or capital CCRs fall above or below reasonable

parameters. CMS sets forth these parameters and the Statewide average CCRs in each year's annual notice of prospective payment rates.

For discharges occurring on or after August 8, 2003, the FI may use a Statewide average CCR if it is unable to determine an accurate operating or capital CCR for a hospital in one of the following circumstances:

1. *New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18.)*
2. *Hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b) of the CFR.*
3. *Other hospitals for whom accurate data with which to calculate either an operating or capital CCR (or both) are not available.*

However, the policies of section 20.1.2.1 part C can be applied as an alternative to the Statewide average.

For those hospitals assigned the Statewide average operating and/or capital CCRs, these CCRs must be updated every October 1 based on the latest Statewide average CCRs published in each year's annual notice of prospective payment rates until the hospital is assigned a CCR based on the latest tentative or final settled cost report or a CCR based on the policies of section 20.1.2.1 part C of this manual.

A hospital is no longer assigned the Statewide average CCR if its CCR falls below 3 standard deviations from the national mean CCR. In such a case, the hospital's actual operating or capital CCR is used.

20.1.2.3 Threshold and Marginal Cost

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The FI, using Pricer, determines an appropriate additional payment for inpatient services where hospital charges for covered services furnished to the beneficiary, adjusted for cost, are extraordinarily high. CMS annually determines, and includes in the annual IPPS Final Rule and in Pricer, the threshold beyond which a cost outlier is paid. The additional payment amount is the difference between the estimated cost for the discharge (determined by multiplying the hospital specific CCR by the hospital's charges for the discharge) and the threshold criteria established for the applicable DRG multiplied by a marginal cost factor of 80 percent. (The marginal cost factor for burn cases is 90 percent, as described in section 20.1.2.8.) CMS includes the marginal cost

factor in Pricer. For more explanation on the calculation of outliers visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp

20.1.2.4 – Transfers

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

A. Transfers Between IPPS Hospitals

For transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day.

The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. For further information on transfers between IPPS hospitals, see section 40.2.4 part A of this manual.

B. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that do not Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the postacute care transfer policy, the transferring hospital is paid the full IPPS rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold and payment are calculated the same as any other discharge without a transfer.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that do not fall within a DRG that is subject to the postacute care transfer policy, see section 40.2.4 part B of this manual.

C. Transfers from an IPPS Hospital to Hospitals or Units Excluded from IPPS that Fall within a DRG that is Subject to the Postacute Care Transfer Policy

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is subject to the postacute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case plus one day. If a discharge is assigned to a special pay DRG subject to the post acute care transfer policy the outlier threshold is equal to the fixed-loss cost outlier threshold for non-transfer cases, divided

by the geometric mean length of stay for the DRG, multiplied by 0.5 plus the product of the length of stay plus one day multiplied by 0.5.

The payment to the final discharging hospital or unit is made at the rate of its respective payment system. For further information on transfers from an IPPS hospital to hospitals or units excluded from IPPS that fall within a DRG subject to the postacute care transfer policy, see section 40.2.4 part C and D.

20.1.2.5 – Reconciliation

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

A. General

Under 42 CFR § 412.84(i)(4), for discharges occurring on or after August 8, 2003, high cost outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. This new regulation was implemented in two phases (further explanation on these two phases is provided below). Hospitals that FIs identified using the criteria in section I.A. of PM A-03-058 (under which FIs identified hospitals whose charges appeared to have been increasing at an excessive rate) are subject to the reconciliation policies described in this section for discharges occurring on or after August 8, 2003. For all other hospitals, reconciliation is effective beginning with discharges occurring in a hospital's first cost reporting period beginning on or after October 1, 2003.

Outlier payments are to be reconciled at the time of cost report final settlement if

1. *The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and*
2. *Total outlier payments in that cost reporting period exceed $500,000.*

To determine if a hospital meets the criteria above, the FI shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR and compute the actual operating CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, FIs shall follow the instructions below in section 20.1.2.7. The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.

The criteria above replaces the criteria published in section III of PM A-03-058. The first criterion requires only a 10 percentage point fluctuation in the operating CCR (and not the capital CCR). However, if a hospital meets both criteria, claims will be reconciled using the operating and capital CCRs from the final settled cost report.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect outlier reconciliation and outlier payments), FIs shall notify the CMS regional and Central Office for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in section 20.1.2.1 (b).

Any cost report that has been final settled prior to the issuance of this manual revision that meets the qualifications for reconciliation shall be reopened. FIs shall issue a reopening notice to the provider and notify the CMS Central Office and regional office that the outlier payments need to be reconciled, using the procedures in 20.1.2.5

B. Reconciling Outlier Payments for those Hospitals Identified in PM A-03-058

As stated above, for a hospital that met the criteria in section I.A. of PM A-03-058, reconciliation begins for discharges occurring on or after August 8, 2003. To establish whether a hospital's outlier payments are subject to reprocessing, FIs determine if the CCR and total outlier payments from the entire cost reporting period meet the two criteria in part A of this section. However, if both criteria for reconciliation are met, only the discharges that occurred between August 8, 2003 and the end of the cost reporting period will be reconciled. These hospitals will be subject to reconciliation in subsequent cost reporting periods if they meet the two criteria outlined in part A of this section. See example A below.

FIs shall notify the CMS regional office and CMS Central Office of any hospital that meets the criteria for reconciliation. Notification to the CMS Central Office shall be sent to the address and email address provided in section 20.1.2.1. Further instructions for FIs on reconciliation and the time value of money are provided below in §§20.1.2.6, 20.1.2.7 and 20.1.2.8.

Example A

Cost Reporting Period: 09/01/2002-08/31/2003

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively or final settled 2002 cost report)

Final settled operating CCR from 09/01/2002-08/31/2003 cost report: 0.50

Total outlier payout in 09/01/2002-08/31/2003 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the provider's claims for discharges from August 8, 2003 through August 31, 2003 shall be reconciled using the correct CCR of 0.50. The same criteria shall be applied to the cost report beginning on 09/01/2003 to determine whether reconciliation of outlier payments for that cost reporting period is

necessary. For details on how to apply multiple CCRs in a cost reporting period, see example C below.

C. Reconciling Outlier Payments for those Hospitals Not Identified in PM A-03-058

Beginning with the first cost reporting period starting on or after October 1, 2003, all hospitals are subject to the reconciliation policies set forth in this section. If a hospital meets the criteria in part A of this section, the FIs shall notify the CMS regional office and CMS Central Office at the address and email address provided in section 20.1.2.1. Further instructions for FIs on reconciliation and the time value of money are provided below in sections 20.1.2.6, 20.1.2.7 and 20.1.2.8. The following examples demonstrate how to apply the criteria for reconciliation:

Example B

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period: 0.40 (In this example, this CCR is from the tentatively settled 2002 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in outlier payments during that cost reporting period, the criteria has been met to trigger reconciliation, and therefore, the FI notifies the CMS regional office and CMS Central Office. The provider's outlier payments for this cost reporting period will be reconciled using the correct CCR of 0.50.

In the event that multiple CCRs are used in a given cost reporting period, FIs should calculate a weighted average of the CCRs in that cost reporting period. (See Example C below for instructions on how to weight the CCRs). The FI shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if reconciliation is required. Again, total outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

Example C

Cost Reporting Period: 01/01/2004-12/31/2004

Operating CCR used to pay original claims submitted during cost reporting period:

- *0.40 from 01/01/2004-03/31/2004 (This CCR could be from the tentatively settled 2001 cost report)*

- *0.50 from 04/01/2004-12/31/2004 (This CCR could be from the tentatively settled 2002 cost report)*

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.35

Total Outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000

Weighted Average CCR: 0.474

CCR	Days	Weight	Weighted CCR
0.40	91	0.248 (91 Days / 366 Days)	(a) 0.099= (0.40 * 0.248)
0.50	275	0.751 (275 Days / 366 Days)	(b) 0.375= (0.50 * 0.751)
TOTAL	**366**		**(a)+(b) =0.4742**

The hospital meets the criteria for reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changed from 0.474 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an outlier payment greater than $500,000 for the entire cost reporting period.

Even if a hospital does not meet the criteria for reconciliation in part A of this section, subject to approval of the CMS Regional and Central Office, the FI has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate. The FI sends notification to the CMS Central Office via the address and email address provided in section 20.1.2.1 (b). Upon approval of the CMS regional and Central Office that a hospital's outlier claims need to be reconciled, FIs should follow the instructions in section 20.1.2.7.

20.1.2.6 Time Value of Money

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under section 20.1.2.5, outlier payment may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled to the date on which the CMS Central Office receives notification from the FI that reconciliation should be performed.

If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of

that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html .

The following formula will be used to calculate the rate of the time value of money.

*(Rate from Web site as of the midpoint of the cost report being settled / 365 or 366) * # of days from that midpoint until date of reconciliation.*

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the FI, or the date an email was received from the FI by the CMS Central Office, whichever is first.

20.1.2.7 Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The following is a step-by-step explanation of how FIs are to notify CMS that reconciliation should be performed and to record reconciled outlier claims for hospitals that meet the criteria for reconciliation:

1) *The FI shall notify the hospital and copy the CMS regional office and CMS Central Office in writing and via email (through the addresses provided in section 20.1.2.1 part B) that the hospital's outlier claims are to be reconciled (a separate notice should be sent to the CMS regional and Central Office before the hospital is formally notified).*

2) *The FI shall submit to the CMS Central Office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report. The FI submits this data (preferably in electronic format) to the CMS Central Office via the addresses provided above. Data fields that shall be submitted include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) and 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.*

3) *CMS Central Office will use data from National Claims History (NCH) to reprocess claims in a Pricer utility program to determine the correct outlier payment amounts.*
4) *CMS Central Office will subtract the Pricer outlier amounts from NCH Value code 17 data to determine the adjustment. CMS will also calculate the time value of money attributable to the adjustment. CMS will provide the FI with a log of individual claims on which the total adjustment was determined.*

5) *The FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.*

6) *The FI shall finalize the cost report, issues an NPR and make the necessary adjustment from or to the provider.*

The CMS Central Office will work as quickly as possible to reconcile these claims in order to allow FIs and finalize the cost report and issue an NPR within the normal CMS timeframes. If the FIs have any questions regarding this process they should contact the CMS central and regional offices, using the address and email address provided in section 20.1.2.1.

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

Example D

Cost Reporting Period: 01/01/2004-12/31/2004

Midpoint of Cost Reporting Period: 07/01/2004

Date of Reconciliation: 12/31/2005

Number of days from Midpoint until date of Reconciliation: 549

Rate from Social Security Web site: 4.625%

Operating CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2002 or 2003 cost report)

Final settled operating CCR from 01/01/2004-12/31/2004 cost report: 0.50

Total outlier payout in 01/01/2004-12/31/2004 cost reporting period: $600,000.

Because the CCR fluctuated from .40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an outlier payout greater than

$500,000, the criteria have been met to trigger reconciliation. The FI notifies the CMS regional office and CMS Central Office.

The CMS Central Office reprocesses the claims. The reprocessing indicates the revised outlier payments are $700,000.

*Using the values above, determine the rate that will be used for the time value of money: (4.625 / 365) * 549 = 6.9565%*

*Based on the claims reconciled, the provider is owed $100,000 ($700,000-$600,000) for the reconciled amount and $6,956.50 ($100,000 * 6.9565 %) for the time value of money.*

20.1.2.8 - Special Outlier Payments for Burn Cases

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates is computed using the same methodology (as stated above in section 20.1.2.3) except that the payment is made using a marginal cost factor of 90 percent instead of 80 percent.

20.1.2.9 - QIO Reviews and Adjustments

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The QIO reviews a sample of cost outlier cases after payment. The charges for any services identified as non-covered through this review are denied and any outlier payment made for these services is recovered, as appropriate, after a determination as to the provider's liability has been made.

If the QIO finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the QIO determines that appropriate corrective actions have been taken.

The QIO reviews the cost outlier cases, using the medical records and itemized charges, to verify the following:

1. *The admission was medically necessary and appropriate;*
2. *Services were medically necessary and delivered in the most appropriate setting;*
3. *Services were ordered by the physician, actually furnished, and not duplicatively billed; and*
4. *The diagnostic and procedural codings are correct.*

Where a QIO's decision changes previously processed bills, an adjustment bill is prepared to correct the bill.

When the hospital provides the QIO with medical records for cost outlier review, the hospital must indicate the precise revenue code for each charge billed. In case adjustments are needed, revenue codes are necessary to ensure proper accounting for cost report purposes. It is not acceptable for the hospital to merely provide listings of revenue codes expecting the QIO to assign the charges to the appropriate code. If the correct revenue codes are not provided, the QIO will deny the bill.

20.1.2.10 Return Codes for Pricer

(Rev. 707, Issued: 10-12-05; Effective/Implementation Dates: 11-07-05)

The following return codes are calculated by PRICER and passed back to the calling program. Depending on the type of payment and case, return codes 30, 44, 33, 40 and 42 indicate that an outlier would be paid if the cost-to-charge ratio would rise by 20 percentage points. If a provider(s) (CCR rises by 10 percentage points and) meets the criteria of reconciliation, the CMS Central Office uses return codes 30, 44, 33, 40 and 42 to determine a smaller pool of claims for reprocessing claims due to outlier reconciliation.

Acute Care

Return Code 00: Paid normal DRG payment

Return Code 02: Paid normal DRG payment plus a cost outlier

Return Code 14: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay

Return Code 16: Paid normal DRG payment plus a cost outlier with per diem days equal to or greater than geometric mean length of stay

Return Code 30: Paid normal DRG payment and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points

Return Code 44: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points

Transfer Cases

Return Code 03: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the

covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated.

Return Code 05: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates case qualified for a cost outlier payment.

Return Code 06: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates provider refused cost outlier payment.

Return Code 33: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points

<u>Post Acute Transfer Cases</u>

Return Code 10: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay the standard payment is also calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 12: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 40: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that have double the

payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points

Return Code 42: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for post acute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points