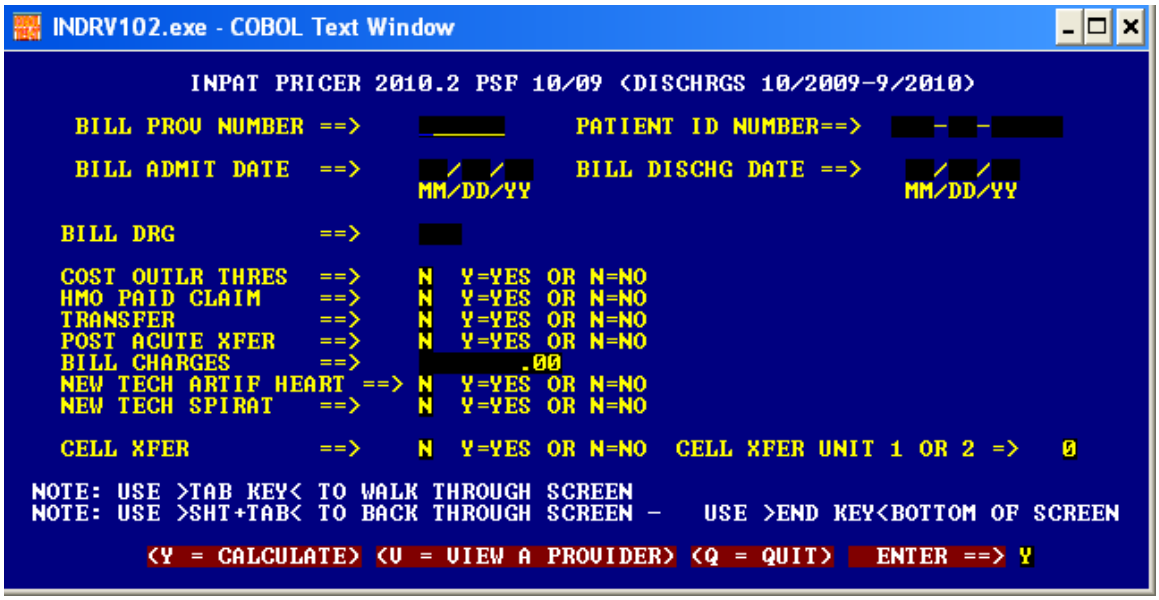
Data Entry and Calculation Steps for the Inpatient PPS PC Pricer

If you selected 'Y' on the PC Pricer HOME screen, you will receive the following screen. This is where you enter claim data, as shown in the screen shot below. Field inputs are explained below the window.



BILL PROV NUMBER – Enter the six-digit OSCAR number present on the claim.

Note: The National Provider Number (NPI) on the claim (if submitted by the hospital) is not entered in this field. Please note that depending on NPI billing rules, a hospital may only submit their NPI number without their OSCAR number. Should this occur, you will have to contact the billing hospital to obtain their OSCAR number as the PC Pricer software cannot process using an NPI.

PATIENT ID NUMBER – Not required, but you can enter the patient's ID number on the claim.

BILL ADMIT DATE – Enter the admission date on the claim (the FROM date in Form Locator (FL) 6 of the UB-04).

BILL DISCHARGE DATE – Enter the discharge date on the claim (the THROUGH date in FL 6 of the UB-04).

BILL DRG – Enter the DRG for the claim. The DRG is determined by the Grouper software or may be on the UB-04 claim form in FL 71.

COST OUTL THRES –N/A for IHS/CHS. Enter 'N' (or tab) if the cost outlier threshold is not applicable for the claim. Enter 'Y' if you want to know the cost outlier

threshold if you are trying to price an outlier claim where Medicare benefits have exhausted (i.e., occurrence code A3).

HMO PAID CLAIM – N/A for IHS/CHS. Enter 'N' (or tab). HMOs must enter 'Y'

Note: Effective with the FY 2010 PC Pricer, when a 'Y' is entered in this field, and the provider is a Sole Community Hospital (SCH), a new field on the PC Pricer output screen will be populated—the 'MA HSP' field. The 'MA HSP' field reflects the payment based on 100% HSP rate. HMOs may compare this amount to the 'TOT OPER AMT' less the 'O-HSP' amount to determine the payment amount for a SCH, that is the greater of the Federal amount or the HSP amount.

TRANSFER – Enter 'Y' if there is a Patient Status Code 02 on the claim. Otherwise, enter 'N' (or tab). Pricer will apply a transfer payment if the length of stay is less than the average length of stay for this DRG.

POST ACUTE XFER – Enter 'Y' if one of the following Patient Status Codes is present on the claim: 03, 05, 06, 62, 63, or 65. Pricer will determine if the post acute care transfer payment will apply depending on the length of stay and the DRG.

BILL CHARGES – Enter the total covered charges on the claim.

For all of the remaining new technology fields, you will enter a 'Y' if there is a procedure code on the claim that is defined within the International Classification of Diseases, Ninth Revision, Clinical Modification. Otherwise, you will enter 'N' (or tab).

Certain new technologies provide for an additional payment. Enter 'Y' in one of the fields below if the corresponding codes are present on the claim.

NEW TECH ARTIF HEART – 37.52 (For the FY 2010 PC Pricer only)

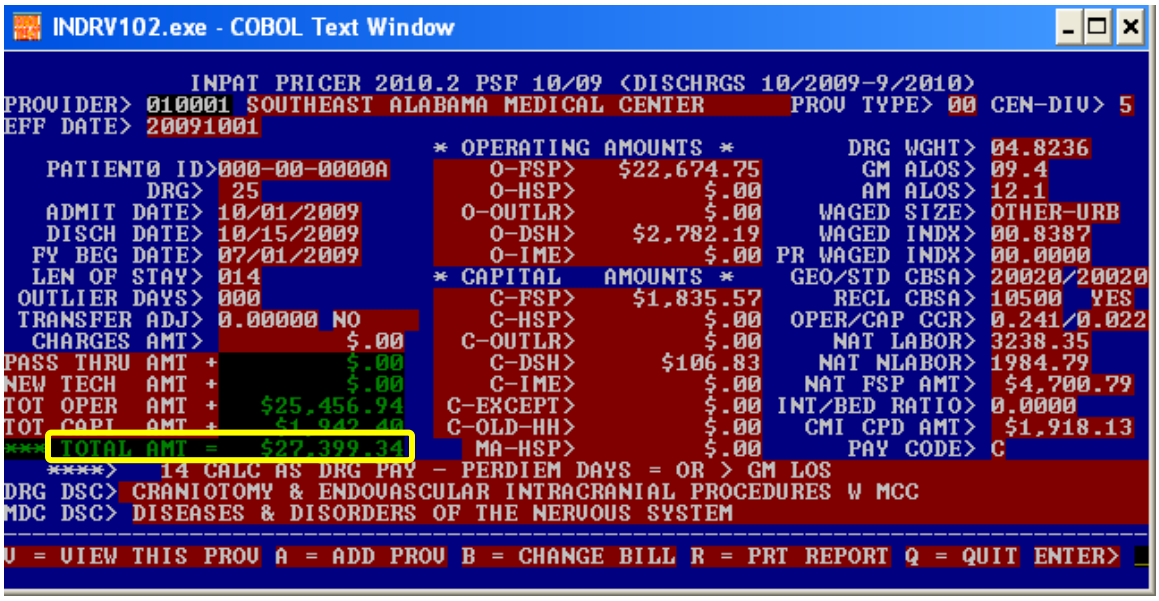
NEW TECH SPIRATION – MS-DRGs 163, 164 or 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49 (For the FY 2010 PC Pricer only)

CELL XFER – 52.85 (described in CR 5505)

CELL XFER UNIT 1 OR 2 – Enter '1' or '2' depending on how many times 52.85 is present. If there is not 52.85 on the claim, enter '0' or simply just tab through the default value.

ENTER ➔ -- Enter 'Y' (or tab through the default value) to calculate.

The following screen is an example of what will appear. Note, some fields may have 0 values depending on the inputs entered in the prior screen.



The TOTAL AMT field is the provider's payment.

A Note on Pass Through Payments in the PC Pricer:

There are certain hospital costs that are excluded from the IPPS payment and are paid on a reasonable cost basis. These are known as pass-throughs and they are as follows:

- DGME
- Capital for the first 2 years of a new hospital (generally 85% of Medicare allowed capital costs)
- Organ acquisition costs (excludes bone marrow transplants)
- CRNA's- for small rural hospitals
- Nursing and allied health education costs

Pass-through Payments under Medicare FFS are usually paid on a bi-weekly interim basis based upon cost determined via the cost report (or data received prior to cost report filing). It is computed on the cost report based upon Medicare utilization (per diem cost for the routine and ancillary cost/charge ratios). In order for the PC Pricer user to estimate what the pass-through payments are, it uses the pass-through per diem fields that are outlined in the provider specific file.

It is important to note that Medicare Advantage plans are not required to pay certain pass-throughs because the hospital is being reimbursed for them already through the bi-weekly payments or through their cost report (as stated above) by their Medicare FFS contractor.

Therefore, for PC Pricer purposes, when a 'Y' is entered in the HMO PAID CLAIM field, organ acquisition and graduate medical education costs are omitted. The PASS THRU AMT is calculated by converting the PASS THRU AMT to a per diem and multiplying it by the number of days for the stay.

**Bad debt is not in the Pricer, and is paid bi-weekly