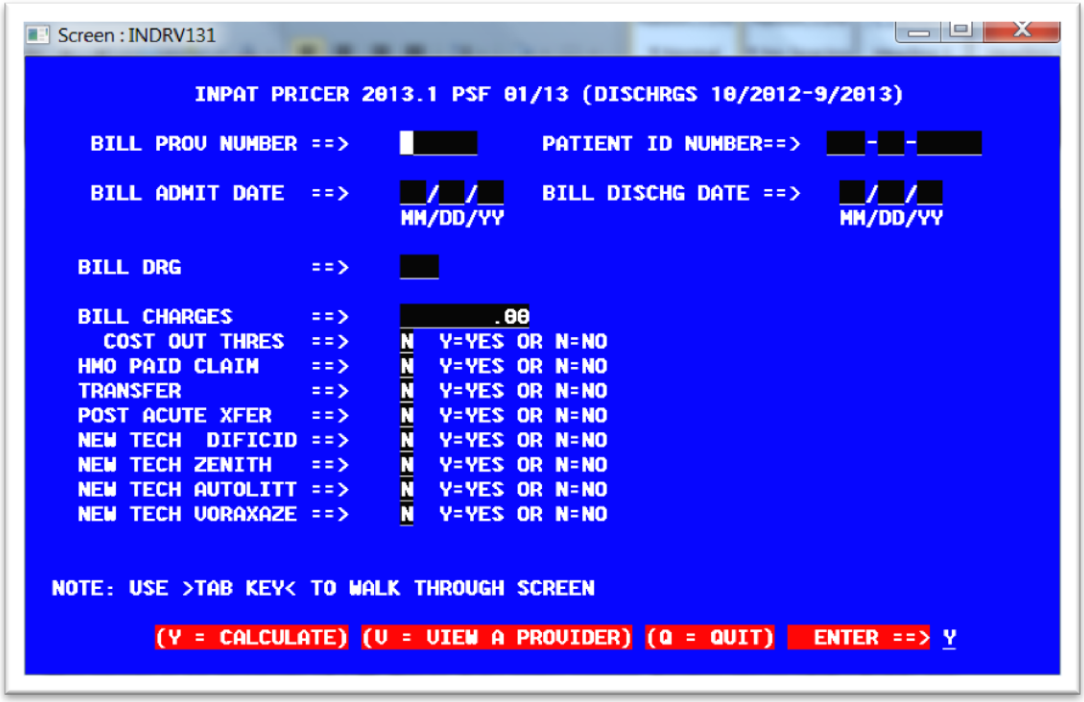
Data Entry and Calculation Steps For the Inpatient PPS PC Pricer

If you selected 'Y' on the PC Pricer HOME screen, you will receive the following screen. Enter claim data on this screen in order to calculate an estimated claim payment. For a description of each field input, please see the descriptions below.



- **BILL PROV NUMBER** – Enter the six-digit CCN (CMS Certification Number) present on the claim.

  NOTE: The National Provider Number (NPI) on the claim (if submitted by the hospital) is in this field. Please note that depending on NPI billing rules, a hospital may only submit their NPI number without their CCN number. Should this occur, you will have to contact the billing hospital to obtain their CCN 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.

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

- **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'

  When a 'Y' is entered in this field, and the provider is a Sole Community Hospital (SCH), the 'MA HSP' field will be populated. The 'MA HSP' field reflects the payment based on 100% Hospital Specific (HSP) rate. HMOs may compare this amount to the 'TOT OPER AMT' less the 'O-HSP' (Operating Hospital Specific Rate) amount to determine the payment amount for a SCH, that is the greater of the Federal amount or the HSP amount.

  When HMO PAID CLAIM field equals 'Y' the Pricer shows the outlier amount if there is an outlier, and then includes that amount in the total payment. The MA plans paying out of network PPS hospitals must pay outliers. For Sole community hospitals, the outliers are paid if operating PPS (including outliers) is greater than the HSP. But unlike Medicare, for MA paying non-network SCHs, the greater of the two is paid on a claim by claim basis with no cost settlement.

  When the HMO PD CLAIM field is set to 'Y' the following pass through payments may be included in the pass through payment field:
  - Capital – for new hospitals during their first 2 years of operation
  - Certified Registered Nurse Anesthetists (CRNAs) - for rural hospitals that perform fewer than 500 surgeries per year
  - Nursing and Allied Health Professional Education - when conducted by a provider in an approved program

  *****Also see the "A Note on Pass through Payments in the PC Pricer" section at the end of the document. *****

- **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** – Applicable to FY 2013, 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.

  NOTE: There are three factors to consider, the discharge status code on the claim, the length of stay, and the MS DRG in whether the post-acute transfer policy applies. Please review our policy (See section 40.2.4 C.) at
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

  Keep in mind that the length of stay must be less than the average length of stay for the DRG. The lists of applicable DRGs are in Table 5 each year in the Federal Register. Please see the link below for the FY 2013 list.
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html

THE FOLLOWING NEW TECHNOLOGY FIELDS ARE APPLICABLE FOR FY 2013:

- **NEW TECH DIFICID** – Enter a "Y" for cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868.

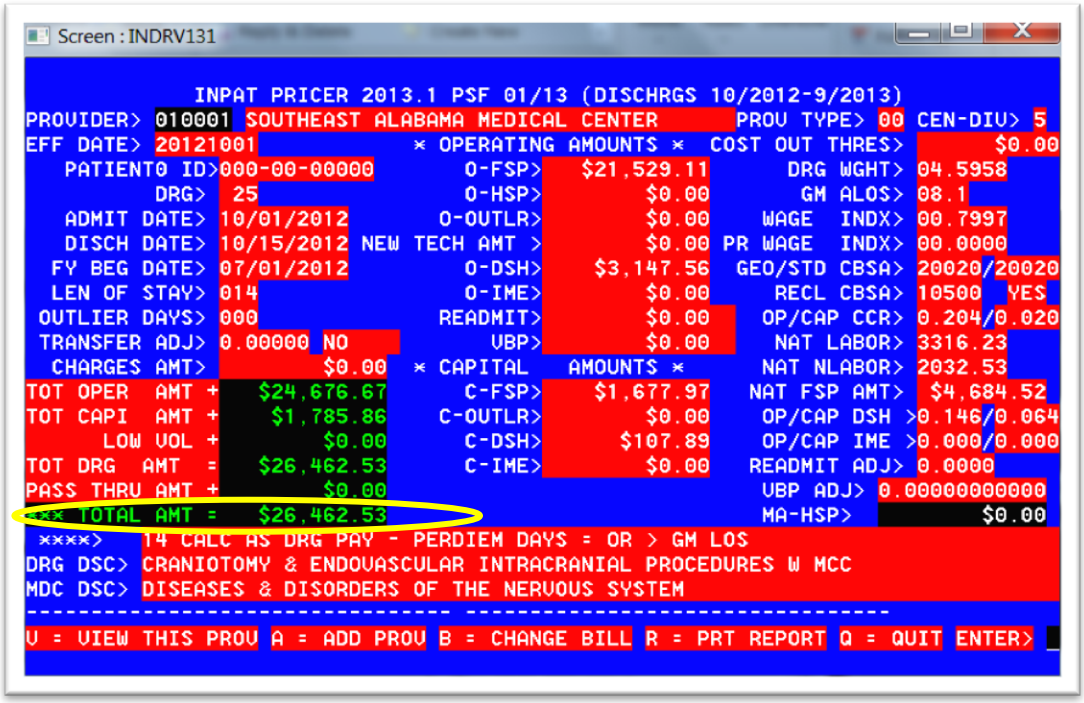
- **NEW TECH ZENITH -** Enter a "Y" for cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.

- **NEW TECH AUTOLITT** – Enter a "Y" for cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

- **NEW TECH VORAXAZE** - Enter a "Y" for cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000.

- **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 $0.00 values depending on the inputs entered in the prior screen.

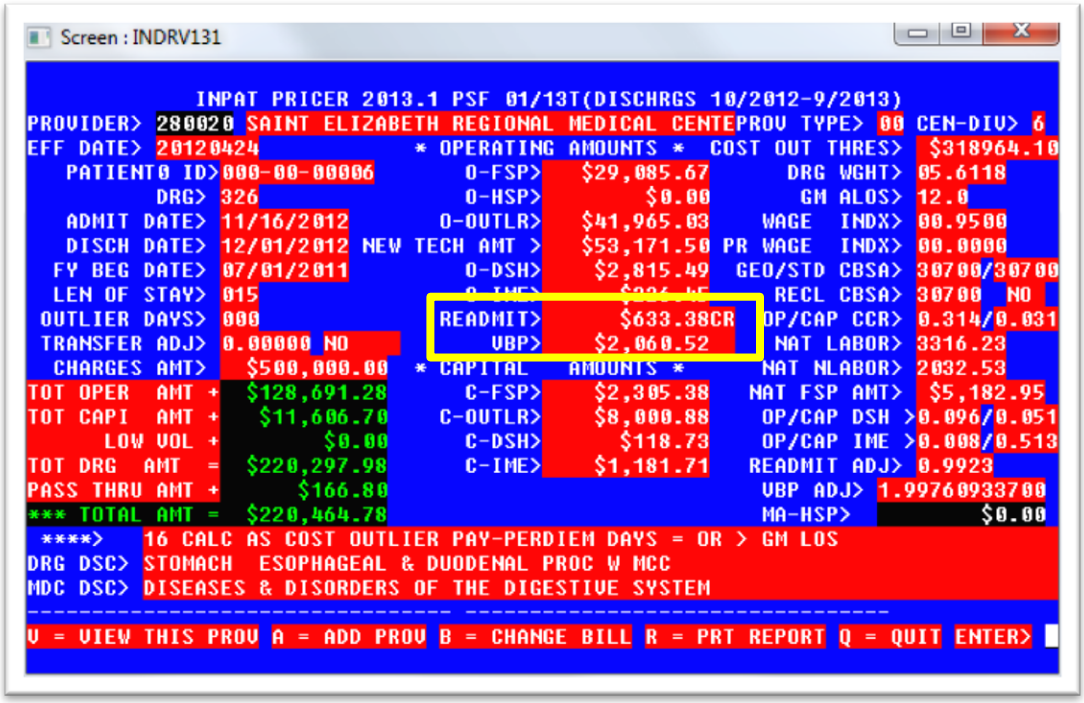
  The **TOTAL AMT** field is the provider's payment.



A Note on Readmission Reduction Program Adjustment and Value Based Purchasing Adjustment (VBP) in the PC Pricer:

There are two new fields due to new payment policies for FY 2013 in the middle of the screen, “READMIT” (Readmission Reduction Program Adjustment) and “VBP” (Value Based Purchasing Adjustment) which can either add or subtract from the claim priced amount. If there is a “CR (claim reduction)” next to the field the field amount was subtracted from the claim total. If there is no “CR (claim reduction)” next to the field amount the amount was added to the claim total.

For additional details on this policy, please refer to the FY 2013 IPPS Final Rule by accessing the following link: http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf



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.) Pass-through payments are 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-through payments because the hospital is already being reimbursed for them through bi-weekly payments or through the 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.

A plan may refer to the MA Payment Guide for Out of Network payments by accessing the following link for additional information.

http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

****BAD DEBT IS NOT IN THE PRICER AND IS PAID BI-WEEKLY ****