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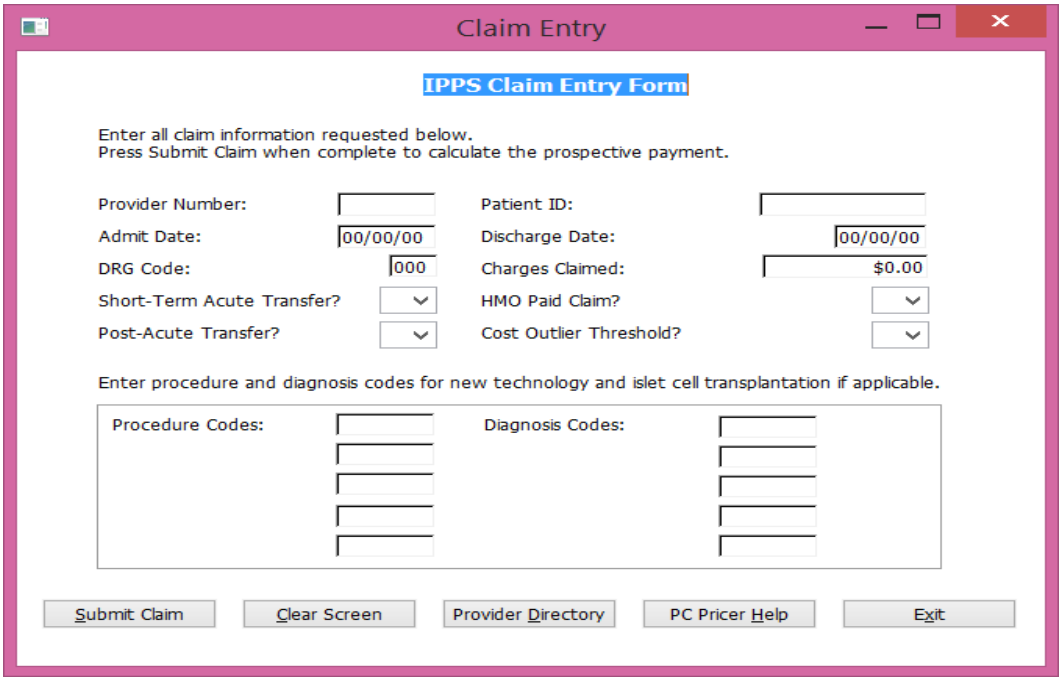
Data Entry and Calculation Steps For the Inpatient PPS PC Pricer

If you selected 'Enter Claim' 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.



- **PROVIDER 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** – Not required, but you can enter the patient's ID number on the claim.

- **ADMIT DATE** – Enter the admission date on the claim (the ADMIT date in FL 12).

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

- **DRG CODE** – 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.

- **CHARGES CLAIMED** - Enter the total covered charges on the claim.

- **SHORT TERM ACUTE TRANSFER** – Enter 'Y' if there is a Patient Status Code 02, 66, 82 or 94 are 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.

- **HMO PAID CLAIM** – N/A for IHS/CHS. Select 'N' from the drop down box. HMOs must select '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. *****

- **POST ACUTE TRANSFER** – Select 'Y' from the drop down box if one of the following Patient Status Codes is present on the claim: 03, 05, 06, 50, 51, 62, 63, 65, 83, 85, 86, 90, 91 or 93. 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 2017 list.

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

- **COST OUTLIER THRESHOLD** – N/A for IHS/CHS. Select 'N' from the drop down box if the cost outlier threshold is not applicable for the claim. Select '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).

The following information should be used for entering procedure and diagnosis codes for new technology and islet cell transplantation if applicable.

The following items will continue to be eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: Defitelio®

- Maximum Add-on Payment: $80,500 (Note, this amount has been updated for FY 2019)
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 or XW04392

2. Name of Approved New Technology: ZINPLAVA™

- Maximum Add-on Payment: $1,900
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033A3
- or XW043A3

3. Name of Approved New Technology: Stelara®

- Maximum Add-on Payment: $2,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XW033F3

The following items will be eligible for new-technology add-on payments in FY 2019:

1. Name of Approved New Technology: VYXEOS™

- Maximum Add-on Payment: $36,425
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033B3 or XW043B3

2. Name of Approved New Technology: Remedē® System

- Maximum Add-on Payment: $17,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 0JH60DZ and 05H33MZ in combination with procedure code: 05H03MZ or 05H43MZ

3. Name of Approved New Technology: GIAPREZA™

- Maximum Add-on Payment: $1,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033H4 or XW043H4

4. Name of Approved New Technology: AndexXa™

- Maximum Add-on Payment: $14,062.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03372 or XW04372

5. **Name of Approved New Technology: Sentinel® Cerebral Protection System™**
- Maximum Add-on Payment: $1,400
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: X2A5312

6. **Name of Approved New Technology: Aquabeam®**
- Maximum Add-on Payment: $1,250
- Identify and make new technology add-on payments with ICD-10-PCS procedure code: XV508A4

7. **Name of Approved New Technology: VABOMERE™**
- Maximum Add-on Payment: $5,544
- Identify and make new technology add-on payments with an NDC of 70842012001 or 65293000901 (VABOMERE™ Meropenem-Vaborbactam Vial)

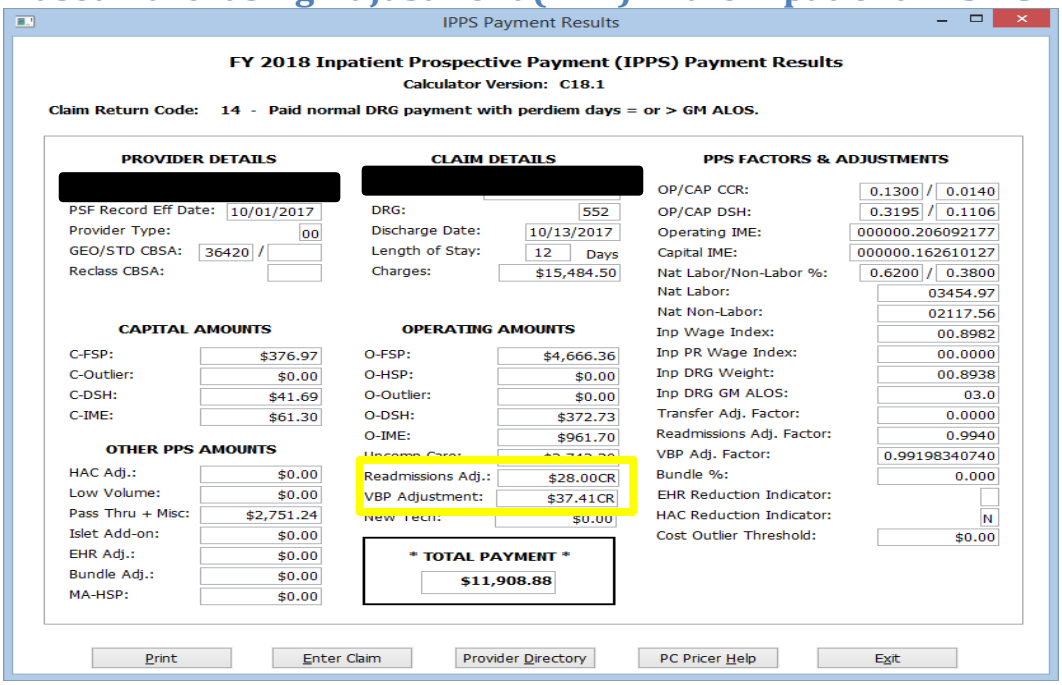
8. **Name of Approved New Technology: ZEMDRI™ (Plazomicin)**
- Maximum Add-on Payment: $2,722.50
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033G4 or XW043G4

9. **Name of Approved New Technology: Kymriah®/Yescarta®**
- Maximum Add-on Payment: $186,500
- Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW033C3 or XW043C3

- **SUBMIT CLAIM** – Click "Submit Claim" to calculate.
  NOTE: Some fields may have $0.00 values depending on the inputs entered in the prior screen.

- **TOTAL AMT** – The amount of the estimated claim payment.

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



There are two new fields due to new payment policies for FY 2013 in the middle of the screen, “READMISSIONS ADJ” (Readmission Reduction Program Adjustment) and “VBP ADJUSTMENT” (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

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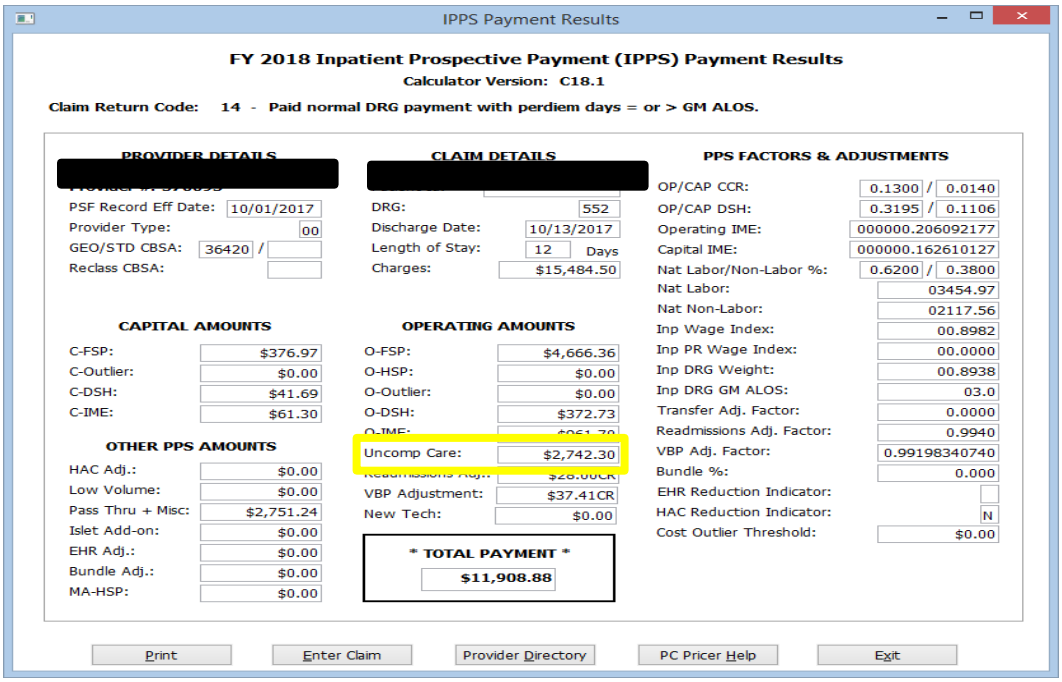
A Note on Uncompensated Care Payments in the Inpatient PPS PC Pricer:



The total uncompensated care payment (UCP) amount and estimated per claim amount to be paid to the Medicare Disproportionate Share Hospitals (DSH) is finalized in the annual IPPS Final Rule. The UCP will be paid on the claim, as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH adjustments. UCP eligibility and payment information is included in the DSH data files for each fiscal year, which may be accessed by navigating to the "Downloads" section on the webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

The estimated per claim amount is determined by dividing the total UCP amount by the average number of claims from the most recent three years of claims data. The estimated per discharge UCP amount will be included in the outlier payment determinations, and will be included as a federal payment in the comparison for Sole Community Hospitals to determine if a claim is paid under the hospital specific rate or federal rate. The total UCP amount finalized in the IPPS Final Rule will be reconciled at cost report settlement with the interim estimated UCP amounts that are paid on a per discharge basis.

Beginning in FY 2014, the UCP estimated per claim amount has been included in the PC Pricer and uses the same information that appears in the DSH Supplemental Data File. In the PC Pricer, when "Y" is entered in the HMO PAID CLAIM field (denoting that the payer is an Medicare Advantage (MA) organization), the UCP estimated per claim amount from the DSH Supplemental File will appear in the Pricers estimated claim payment calculation in the field labeled "UNCOMP CARE."

Last Update: 1/23/2019

A Note on Pass Through Payments in the Inpatient PPS 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 ****