

C Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction 9 Providers

May 2014



In this issue

Manual update regarding appeal of claims.....	4
Local coverage determinations.....	11
Implementation of phase III CORE 360 CARCs.....	17
Physician fee schedule database update.....	21
FQHC prospective payment system.....	24
Upcoming educational events	31

CMS issues proposed hospital inpatient payment regulation

Proposed rule would strengthen tie between payment and quality improvement

On April 30, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update fiscal year (FY) 2015 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs).

This rule builds on the Obama administration's efforts through the Affordable Care Act to promote improvements in hospital care that will lead to better patient outcomes while slowing the long-term health care cost growth.

CMS projects that the payment rate update to general acute care hospitals will be 1.3 percent in FY 2015. The rate update for long term care hospitals will be 0.8 percent. The difference in the update is accounted for by different statutory and regulatory provisions that apply to each system.

The rule's most significant changes are payment provisions intended to improve the quality of hospital care that reduce payment for readmissions, and hospital acquired

conditions (HACs). The rule also includes proposed changes to the hospital inpatient quality reporting (IQR) program. The rule also describes how hospitals can comply with the Affordable Care Act's requirements to disclose charges for their services online or in response to a request, supporting price transparency for patients and the public.

The proposed rule asks for public input on an alternative payment methodology for short stay inpatient cases that also may be treated on an outpatient basis, including how to define short stays. In addition, the proposed rule reminds stakeholders of the existing process for requesting additional exceptions to the two-midnight benchmark.

Improving patient care

Hospital value-based purchasing program: The hospital value-based purchasing (VBP) program, which was established by the Affordable Care Act, adjusts payments to hospitals under the IPPS based on the quality of care they deliver to patients.

See **REGULATION**, Page 3



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

General information

Manual update regarding appeal of claims decisions.....	4
Fluorodeoxyglucose positron emission tomography for solid tumors.....	4
Updates and clarifications to the hospice policy chapter of the benefit policy manual.....	5
Mandatory reporting of eight-digit clinical trial numbers.....	7

General coverage

FDG PET scan for solid tumors.....	9
------------------------------------	---

Local coverage determinations

Advance beneficiary notice.....	11
Doxorubicin, liposomal (Doxil/Lipodox) – revision to the Part A LCD.....	12
Collagenase clostridium histolyticum (Xiaflex®) – revision to the Part A LCD.....	12
Noncovered services – revision to the Part A LCD.....	13
Therapy and rehabilitation services – revision to the Part A LCD.....	13
Testosterone pellets (Testopel®).....	14
Transcranial magnetic stimulation for major depressive disorder.....	15
No changes to LCDs with new CMS contract.....	15

Electronic data interchange

Common working file editing for vaccines furnished at hospice – correction.....	16
ICD–10 limited end-to-end testing with submitters.....	16
Implementation of phase III CORE 360 CARCs and RARCs rule.....	17

Claims and inquiry summary data

Top inquiries.....	18
Top rejects.....	19
Return to provider claims.....	20

Reimbursement

Medicare physician fee schedule database April update.....	21
Implementation of a FQHC prospective payment system.....	24
July 2014 quarterly ASP Medicare Part B drug pricing files.....	27

Hospitals

New fields in the inpatient hospital provider specific file.....	28
Instructions for incorporating GME caps in cost reports.....	29
Inpatient psychiatric facility claims teaching adjustments not displaying correctly.....	29
Anesthesiology services in a method II critical access hospital.....	30

Educational events and resources

Provider outreach and educational events.....	31
CMS MLN Connects™ Provider eNews.....	32
Medicare billing certificate programs.....	32
Medicare Speaks – Fort Lauderdale July 22-23.....	32
Florida/USVI contact information.....	33
Puerto Rico contact information.....	34

Appendix A

Change request 8633: Instructions for incorporating GME caps in cost reports.....	35
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General Information

REGULATION

From Front Page

For FY 2015, as directed by the law, CMS is increasing the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, to 1.5 percent of the base operating DRG payment amounts to all participating hospitals. CMS estimates that the total amount available for value-based incentive payments in FY 2015 will be approximately \$1.4 billion, and will update this estimate in the FY 2015 IPPS/LTCH final rule.

Hospital readmissions reduction program: The maximum reduction in payments under the hospital readmissions reduction program will increase from 2 to 3 percent as required by law. For FY 2015, CMS proposes to assess hospitals' readmissions penalties using five readmissions measures endorsed by the National Quality Forum (NQF). Already, CMS estimates that hospital readmissions in Medicare declined by a total of 150,000 from January 2012 through December 2013.

Hospital-acquired condition reduction program: CMS proposes to implement the Affordable Care Act's hospital acquired condition (HAC) reduction program. Beginning in FY 2015, hospitals scoring in the top quartile for the rate of HACs (i.e. those with the poorest performance) will have their Medicare inpatient payments reduced by one percent.

This new program builds on the progress in this area achieved through the existing HAC program, which is currently saving approximately \$25 million annually by reducing Medicare payments when certain conditions that are reasonably preventable are acquired in the hospital.

Quality reporting programs: The proposed rule would revise measures for the hospital inpatient quality reporting, long-term care hospital (LTCH) quality reporting and PPS-exempt cancer hospital quality reporting programs. CMS

proposes to align for 2015 and 2016 the reporting and submission timelines for clinical quality measures for the Medicare electronic health record (EHR) incentive program with the reporting and submission timelines of the hospital IQR program.

Wage index – updated labor market areas: In order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions, we are proposing to use the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 census data.

In order to mitigate potential negative payment impacts due to the proposed adoption of the new OMB delineations, CMS is proposing a one-year transition for all hospitals that would experience a decrease in their actual payment wage index exclusively due to the proposed implementation of the new OMB delineations, and a three-year transition for hospitals currently located in an urban county that would become rural under the new OMB delineations.

CMS will accept comments on the proposed rule until June 30, 2014, and will respond to comments in a final rule to be issued by August 1, 2014.

[Proposed rule](#)

[Press release](#)

[Fact sheet, CMS Proposals to Improve Quality of Care during Hospital Inpatient Stays](#)

[Fact sheet, Fiscal Year 2015 Proposed Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals](#)



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Manual update regarding appeal of claims decisions

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs and home health and hospices (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8588, which updates the *Medicare Claims Processing Manual* (Chapter 29 (Appeals of Claims Decisions)) with various policy clarifications. Make sure that your billing staffs are aware of these updates.

Background

CR 8588 revises the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions)) and adds various policy clarifications regarding appeals of claims decisions. These revisions include the following:

- A definition of spouse following the June 2013 Supreme Court ruling that invalidated Section 3 of the Defense of Marriage Act (DOMA) (Section 110)
- Clarification of existing instructions in regard to the following:
 - The submission of appointment of representative written instruments (Section 270.1.3)
 - The handling and reporting of defective or missing appointment instruments (Section 270.1.6), and

- Signature requirements for appointment of representative instruments (Section 270.1.2)

A copy of the revised *Medicare Claims Processing Manual* (Chapter 29 (Appeals of Claims Decisions)) is included as an attachment to CR 8588.



Additional information

The official instruction, CR 8588, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2926CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

MLN Matters[®] Number: MM8588
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 Effective Date: July 14, 2014
 Related CR Transmittal #: R2926CP
 Implementation Date: July 14, 2014

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Fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors

*Note: This article was rescinded and replaced by *MLN Matters*[®] article MM8739. The related change request (CR) 8468 was also rescinded and replaced by CR 8739.*

MM8739 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8739.pdf>.

This information was previously published in the *February 2014 Medicare A Connection, Pages 17-18*.

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 Related Change Request (CR) #: CR 8468

Related CR Release Date: February 6, 2014
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 Implementation Date: March 7, 2014: Non-shared
 System Edits, July 7, 2014: Shared System Edits

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Updates and clarifications to the hospice policy chapter of the benefit policy manual

Provider types affected

This *MLN Matters*[®] article is intended for hospices submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8727, which updates the *Medicare Benefit Policy Manual*, Chapter 9, to incorporate policy language from existing regulations, prior rules, an Office of Inspector General *Memorandum Report*, and two CRs, and to clarify existing policy. No changes were made to existing policies. Make sure your billing staffs are aware of these manual updates.

Background

The hospice portion of the *Medicare Benefit Policy Manual* describes Medicare policies related to eligibility, coverage, payment, some conditions of participation, and beneficiary cost-sharing. It is based on the hospice regulations found in 42 *Code of Federal Regulations* (CFR), Part 418, and clarifications made in rulemaking.

In response to industry questions and concerns, the Centers for Medicare & Medicaid Services (CMS) finalized regulations related to discharge in the November 22, 2005, *Hospice Care Amendments final rule* (70 *Federal Register* (FR) 70532).

These regulations outlined requirements for discharging a patient if the patient or family member(s) became uncooperative or hostile, to the extent that hospice staff could not provide care to the patient, known as discharge-for-cause. This rule also implemented a discharge planning process to deal with the prospect that a patient's condition might stabilize or otherwise change such that the patient can no longer be certified as terminally ill.

In the August 31, 2007, *Hospice Wage Index Final Rule* (72 FR 50214), CMS clarified the requirements for providing general inpatient care (GIP). This clarification occurred as a result of concerns that some hospices were seeking payment for GIP for circumstances where the hospice patient did not meet the criteria given in section 1861(dd)(1)(G) of the Act or in regulation at Section 418.202(e).

CMS clarified that to provide GIP care, the intensity of interventions required for pain and symptom management must be such that care cannot be provided in any other setting but an inpatient setting. CMS wrote that a breakdown of caregiver support should not be billed as

GIP unless the coverage requirements for GIP have been met.

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th day recertification and every recertification thereafter, and to attest that the encounter occurred.

CMS proposed and implemented policies related to this new requirement in the *Home Health Prospective Payment System Rate Update for 2011: Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule* (75 FR 70372). This new face-to-face encounter requirement became effective January 1, 2011.

In the August 4, 2011, *FY 2012 Hospice Wage Index final rule* (76 FR 47302), CMS further clarified that any hospice physician could conduct the face-to-face encounter, and that the attestation of the hospice clinician performing the encounter must note that the clinical findings of the visit were provided to the certifying physician, for use in determining continuing eligibility for hospice services.

On March 31, 2008, the Office of Inspector General (OIG) issued a Memorandum Report March 31, 2008, entitled *Hospice Beneficiaries' Use of Respite Care* (OEI 02-06-00222), which noted that providing respite care to Medicare hospice beneficiaries who reside in nursing facilities is inappropriate.

On October 7, 2011, CMS issued CR 7478, which noted that when a face-to-face encounter is untimely, the beneficiary is not considered terminally ill for Medicare purposes due to lack of recertification, and therefore is not eligible for the hospice benefit. This CR required that a hospice must discharge the patient from the Medicare hospice benefit but can re-admit once the encounter occurs.

Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, CMS expects the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

CR 7478 is explained in MM7478, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7478.pdf>.

See **HOSPICE**, next page



HOSPICE

From previous page

On February 3, 2012, CMS issued CR 7677, which clarified circumstances where discharge from moving outside of a hospice’s service area could occur. This CR gave examples, including but not limited to when a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation.

A discharge may also be appropriate when a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient.

Medicare’s expectation is that the hospice provider would consider the amount of time the patient is in that facility, and the effect on the plan of care, before making a determination that discharging the patient from the hospice is appropriate.

CR 7677 is explained in MM7677, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7677.pdf>.

CR 8727 updates the *Medicare Hospice Benefit Policy Manual* to reflect policy changes or policy clarifications made previously through rulemaking, by the OIG, or through other CRs, as noted above. As part of the update, existing payment policy regulation text was also added to the manual if it was missing.

Finally, there were a number of edits to update the manual language to reflect new terminology (for example, “managed care” instead of “HMO”) or to improve readability (for example, providing a bulleted list of requirements for coverage rather than a paragraph listing of requirements for coverage).

Additional edits were made to incorporate previous policy responses to some common questions, such as that the physician narrative may be dictated, or that oral certifications do not need to be signed by the certifying physician. The manual continues to describe existing hospice policy; no policy changes or new policy is included in this manual.



Additional information

The official instruction, CR 8727, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188BP.pdf>. The revised Chapter 9 of the manual is part of CR 8727.

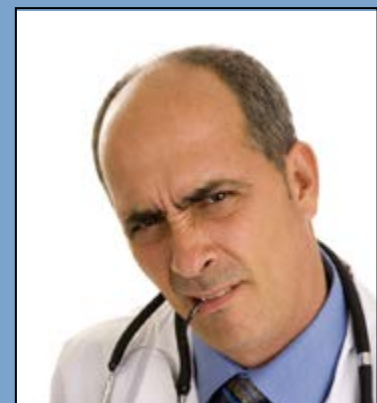
If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work*.

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 Related CR Release Date: May 1, 2014
 Effective Date: August 4, 2014
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 Implementation Date: August 4, 2014

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Mandatory reporting of eight-digit clinical trial numbers

Note: This article was revised May 15, 2014, to reflect the revised change request (CR) 8401 issued May 13. The article has been revised to delete information regarding entry of the clinical trial number on institutional paper or direct data entry (DDE) claim UB-04. Also, the transmittal number, the CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the [November 2013 Medicare A Connection, Pages 16-17](#).

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider action needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD) manual, Section 310.1*.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008.

That is the number assigned by the National Library of Medicine (NLM) <http://clinicaltrials.gov/> website when a new study appears in the NLM Clinical Trials data base. Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-Digit Clinical Trial Number on Claims" is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf>.

The *MLN Matters*[®] article for CR 5790 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf>.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT'.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry.

Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of



importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html>.

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the eight-digit clinical trial number preceded by the two alpha characters of CT must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an eight-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below.

- Claim adjustment reason code (CARC) 16: "Claim/ service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject

See **TRIALS**, next page

TRIALS

From Previous Page

Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)”

- RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”
- RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”
- Group code: Contractual obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2955CP.pdf>. See *MLN Matters*® article SE1344 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network->

[MLN/MLNMattersArticles/downloads/SE1344.pdf](#)) for information on an interim alternative method of satisfying the requirement in CR 8401 for providers who do not have the ability to submit the clinical trial number for trial related claims.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-complianceinteractive-map/index.html>.

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General Coverage

FDG PET scan for solid tumors (fully replaces MM8468)

Provider types affected

This *MLN Matters*[®] article is intended for physicians, providers and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three fluorodeoxyglucose (FDG) positron emission tomography (PET) scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the *National Coverage Determinations (NCD) Manual* to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR 8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) Code A9552) only.

Note: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (PI modifier) FDG PET scan and three (3) subsequent treatment strategy (PS modifier) FDG PET Scans without the KX modifier. The fourth FDG PET scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the KX modifier. If a different cancer diagnosis is reported, whether reported with a PI modifier or a PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (PS modifier) claims.



Providers may refer to Attachment 1 of CR 8739 for a list of appropriate diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions **without** requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- V70.7: Examination of participant in clinical research; or
- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the KX modifier is not included, identified by *Current Procedural Terminology (CPT)*[®] codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier PS, HCPCS A9552, and the same cancer diagnosis code:

- Claim adjustment reason code (CARC) 96: "Non-Covered Charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance advice remarks code (RARC) N435: "Exceeds number/frequency approved/allowed within time period without support documentation."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier

See **PET**, next page

PET

From previous page

indicating a signed ABN is on file.

- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will not search their files to adjust claims processed prior to implementation of CR 8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

Synopsis of coverage of FDG PET for oncologic conditions

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

FDG PET for cancers tumor type	Initial treatment strategy (formerly “diagnosis” & “staging”	Subsequent treatment strategy (formerly “restaging” & “monitoring response to treatment”
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover with exceptions*	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Prostate	Non-cover	Cover
Thyroid	Cover	Cover
Breast (male and female)	Cover with exceptions*	Cover

FDG PET for cancers tumor type	Initial treatment strategy (formerly “diagnosis” & “staging”	Subsequent treatment strategy (formerly “restaging” & “monitoring response to treatment”
Melanoma	Cover with exceptions*	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed	Cover	Cover

***Cervix:** Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

***Breast:** Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

***Melanoma:** Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

Additional information

The official instruction, CR 8739, issued to your MAC regarding this change, is available at in two transmittals at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2932CP.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R168NCD.pdf>.

MLN Matters® Number: MM8739
 Related Change Request (CR) #: CR 8739
 Related CR Release Date: May 28, 2014
 Effective Date: June 11, 2013
 Related CR Transmittal #: R2932CP, R168NCD
 Implementation Dates: May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS shared system edits

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Local Coverage Determinations

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical coverage Web page at <http://medicare.fcso.com/Landing/139800.asp> for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048



Advance beneficiary notice

- Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary.
- Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ**.

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. *Click here* to look up current LCDs



Revised LCDs

Doxorubicin, liposomal (Doxil/Lipodox) – revision to the Part A LCD

LCD ID number L28827 (Florida)
LCD ID number L28860
(Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil/Lipodox) was revised to include the off-label indication of endometrial carcinoma.

The “Indications and Limitations of Coverage and /or Medical Necessity” section of the LCD was revised to include this off-label indication, and the “ICD-9 Codes that Support Medical Necessity” section was updated to add the correlating diagnosis code 182.0. In addition, the “Sources of Information and Basis of Decision” section was updated.

Effective date

The LCD revision is effective for services rendered **on or after April 30, 2014**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

Collagenase clostridium histolyticum (Xiaflex®) – revision to the Part A LCD

LCD ID number L31223
(Florida, Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for collagenase clostridium histolyticum (Xiaflex®) was revised to include the indication of Peyronie’s disease, which was FDA-approved December 6, 2013.

The “Indications and Limitations of Coverage and/ or Medical Necessity” section of the LCD was revised to add the indication of Peyronie’s disease; the “ICD-9 Codes that Support Medical Necessity” section was updated to add the correlating diagnosis code 607.85.

Also, the following sections were updated to include language on Peyronie’s disease: “Documentation Requirements,” “CPT®/HCPCS Codes,” and “Utilization Guidelines.” In addition, the “Sources of Information and Basis for Decision” section was updated, as well as, the “Coding Guidelines” attachment.

In addition, the “Indications and Limitations of Coverage and /or Medical Necessity” section of the LCD was

also revised to clarify verbiage related to Dupuytren’s contractures and anticoagulation medication.

Effective date

The revision related to the FDA approval for Peyronie’s disease is effective for claims processed **on or after May 8, 2014**, for services rendered **on or after December 06, 2013**.

The revision related to Dupuytren’s contractures is effective for services rendered **on or after May 8, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

[Click here](#) to explore the wide array of training opportunities.



Noncovered services – revision to the Part A LCD

LCD ID number L28991 (Florida) LCD ID number L29023 (Puerto Rico, U.S. Virgin Islands)

The following *Current Procedural Terminology*® (CPT®) codes were evaluated and were determined not to meet the Medicare reasonable and necessary threshold for coverage. Therefore, Category III CPT® codes 0335T, 0336T, 0337T, 0340T, 0341T, 0342T, and 0346T have been added to the “CPT®/HCPCS-codes” section of the LCD.

Any denied claim would have Medicare’s appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

Any interested stakeholder can request a reconsideration of an LCD after the notice period. In the case of the noncovered services, LCD the stakeholder will receive a list of the articles and related information in the public

domain that were addressed by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list, LCD reconsideration can be initiated. It is

the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.



Effective date

This LCD revision is effective for services rendered **on or after June 30, 2014**. First Coast Service Options Inc. LCDs are available through the

CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

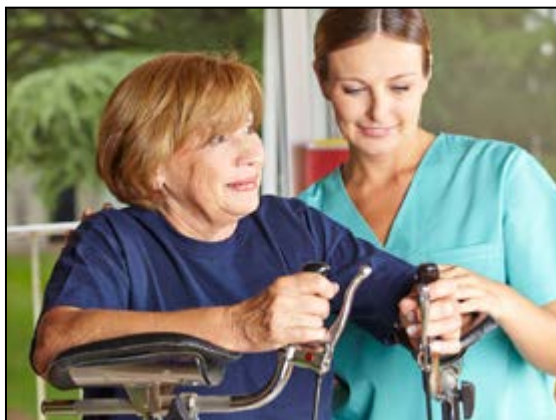
Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

Therapy and rehabilitation services – revision to the Part A LCD

LCD ID number L28992 (Florida) LCD ID number L29024 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised January 01, 2014.

Since that time, the LCD was updated to reflect current Centers for Medicare & Medicaid Services (CMS) language based on change request (CR) 8458 (manual updates to clarify skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), home health (HH), and outpatient (OPT) coverage pursuant to *Jimmo vs Sebelius*).



Effective date

This LCD revision is effective for services rendered **on or after January 07, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

Testosterone pellets (Testopel®) – revision to the Part A LCD “Coding Guidelines” attachment

LCD ID number L33004

(Florida, Puerto Rico, U.S. Virgin Islands)

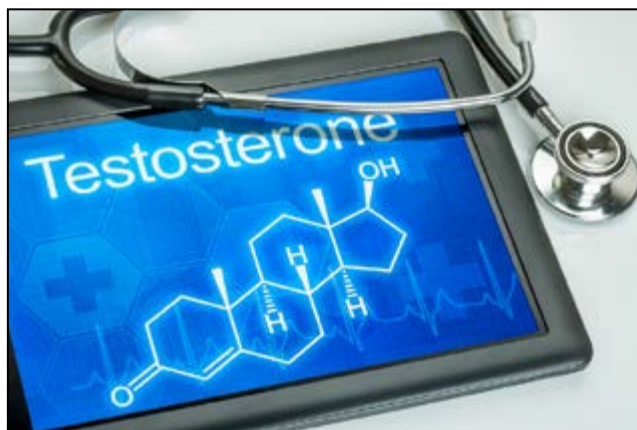
The local coverage determination (LCD) for testosterone pellets (Testopel®) became effective for services rendered on or after January 29, 2013. First Coast Service Options Inc. (First Coast) identified upon pre-payment claims review that Healthcare Common Procedure Coding System (HCPCS) code J3490 (unclassified drugs) used for testosterone pellets (Testopel®) is being billed incorrectly. Also, the medical record for various claims did not support the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

As outlined under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD testosterone pellets are considered medically reasonable and necessary for **second line** testosterone replacement therapy

in males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism when other standard replacement [intramuscular (IM), buccal, transdermal] has not been clinically effective for the given patient.

The review of medical records revealed the following: Providers are not supporting the medical need for testosterone pellets with documentation of unsuccessful treatment of standard replacement (e.g., intramuscular (IM), buccal, transdermal); providers are not specifically addressing the reason(s) for a transition to pellets from other effective testosterone replacement, and lastly some medical records did not include two total testosterone levels and free levels (when indicated) to establish the need for testosterone replacement.

The medical record should include the Clinical Laboratory Improvement Amendments (CLIA) approved reference normal range for the total testosterone assay used.



For HCPCS code J3490, the pre-payment claims review also revealed that providers are not entering the drug's name and dosage when submitting a claim. The provider must indicate the name, strength, and dosage of the drug in block 19 on the CMS-1500 (02/12) paper claim form (or in 2400.SV101-7 in the ANSI 837 claim file). For example, block 19 might state: testosterone pellets (Testopel®), 75 mg per pellet, implanted 225 mg (three pellets). If a compounded form of testosterone pellets is used, this

must be indicated in block 19 with the name, strength, and dosage as described in the above example.

Providers are instructed to continue to bill HCPCS code J3490 for testosterone pellets (Testopel®) and *Current Procedural Terminology*® (CPT®) code 11980 (subcutaneous hormone pellet implantation) on the same claim. If these codes are not billed on the same claim the claim may be subject to prepayment review. Please

note if HCPCS code J3490 is denied then the associated implantation code (CPT® code 11980) will also be denied. The LCD “Coding Guidelines” attachment has been revised to incorporate the billing instructions as stated above.

Effective date

The revision to the LCD “Coding Guidelines” attachment is effective for claims processed **on or after May 6, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

Transcranial magnetic stimulation (TMS) for major depressive disorder – revision to the Part A LCD

LCD ID number L33676 (Florida, Puerto Rico, U.S. Virgin Islands)

This local coverage determination (LCD) for Transcranial magnetic stimulation (TMS) was revised under the “Indications and limitations of coverage and/or medical necessity” section of the LCD, to clarify the appropriate training and certification requirements of the psychiatrist, neurologist, and the technician performing TMS therapy.

The prescribing and supervising psychiatrist and neurologist must have met all of the following criteria:

- Completed a fellowship or residency in psychiatry or neurology
- Completed and demonstrated proficiency in TMS device at a university-based training course or a company sponsored training course.
- Provides personal supervision for the initial individual motor threshold determinations, treatment parameter definition, and TMS treatment course planning and documentation supportive of the level of supervision.
- Subsequent delivery and management of TMS sessions may be performed by a psychiatrist or neurologist and/or an appropriately trained technician under the direct supervision of the professional provider, psychiatrist, or neurologist, to ensure the



patient has someone in attendance at all times during the TMS session.

- During subsequent delivery and management of TMS sessions the providing psychiatrist or neurologist must meet face to face with the patient when there is a change in the individual's mental status and /or other significant change in clinical status.

- Note:** A technician must be directly supervised by a professional provider that is a psychiatrist or neurologist.

- In addition, further revisions were made to the “Indications of Coverage”, “Coverage Limitations and “Documentation Requirements” sections of the LCD.

Effective date

This LCD is effective for services rendered **on or after**

July 7, 2014. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please [click here](#).

No changes to LCDs with new CMS contract

On February 14, 2014, the Centers for Medicare & Medicaid Services (CMS) selected First Coast Service Options Inc. (First Coast) to continue to be the Medicare administrative contractor (MAC) for Florida, Puerto Rico and U.S. Virgin Islands.

As a result of the transition to the new contract, effective June 16, 2014, jurisdiction 9 (J9) will be referred to as jurisdiction (JN). The current MAC J9 LCDs will transition to MAC JN and will retain the same identifying

numbers in CMS’ Medicare coverage database (MCD).

Since First Coast will retain the same contractor identification numbers that are currently listed in the MCD, no changes will be made to the content or to the method of accessing LCDs as result of the transition to JN. First Coast looks forward to continuing to serve the beneficiary and provider communities in JN.

Note: The transition from J9 to JN will be completed by June 16, 2014.

Electronic Data Interchange

Common working file editing for vaccines furnished at hospice – correction

Note: This article was revised May 1, 2014, to reflect the revised change request (CR) 8620 issued April 28. In the article, we added a reference to home health and hospice (HH&H) MACs. Also, the CR transmittal number, the CR release date, and the Web address for accessing the CR are revised. This information was previously published in the February 2014 Medicare A Connection, Page 35-36.

Provider types affected

This *MLN Matters*® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare administrative contractors (MACs), including HH&H MACs.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

Background

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "only when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

Key points

- Your MAC will allow professional claims for vaccines (influenza, PPV, and hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.

ICD-10 limited end-to-end testing with submitters

Note: This article was rescinded May 7, 2014, since the related change request 8602 was rescinded.

This information was previously published in the *March 2014 Medicare A Connection*, Pages 14-15.

MLN Matters® Number: MM8602 Rescinded
Related Change Request (CR) #: CR 8602
Related CR Release Date: February 21, 2014
Effective Date: July 7, 2014



- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

Additional information

The official instruction, CR 8620, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1373OTN.pdf>.

MLN Matters® Number: MM8620 Revised
Related Change Request (CR) #: CR 8620
Related CR Release Date: April 28, 2014
Effective Date: October 1, 2013
Related CR Transmittal #: R1373OTN
Implementation: April 7, 2014

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Related CR Transmittal #: R1352OTN
Implementation Date: July 7, 2014

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Implementation of phase III CORE 360 CARCs and RARCs rule – version 3.0.5

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule.

If you use Medicare’s PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions.

This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the code combination list on or about June 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

(Visit <http://www.wpc-edi.com/> reference for CARC



and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.)

Note: Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 uniform use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group code for a minimum set of four business scenarios.

Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1378OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work?*

MLN Matters® Number: MM8711
Related Change Request (CR) #: CR 8711
Related CR Release Date: May 2, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1378OTN
Implementation Date: September 2, 2014

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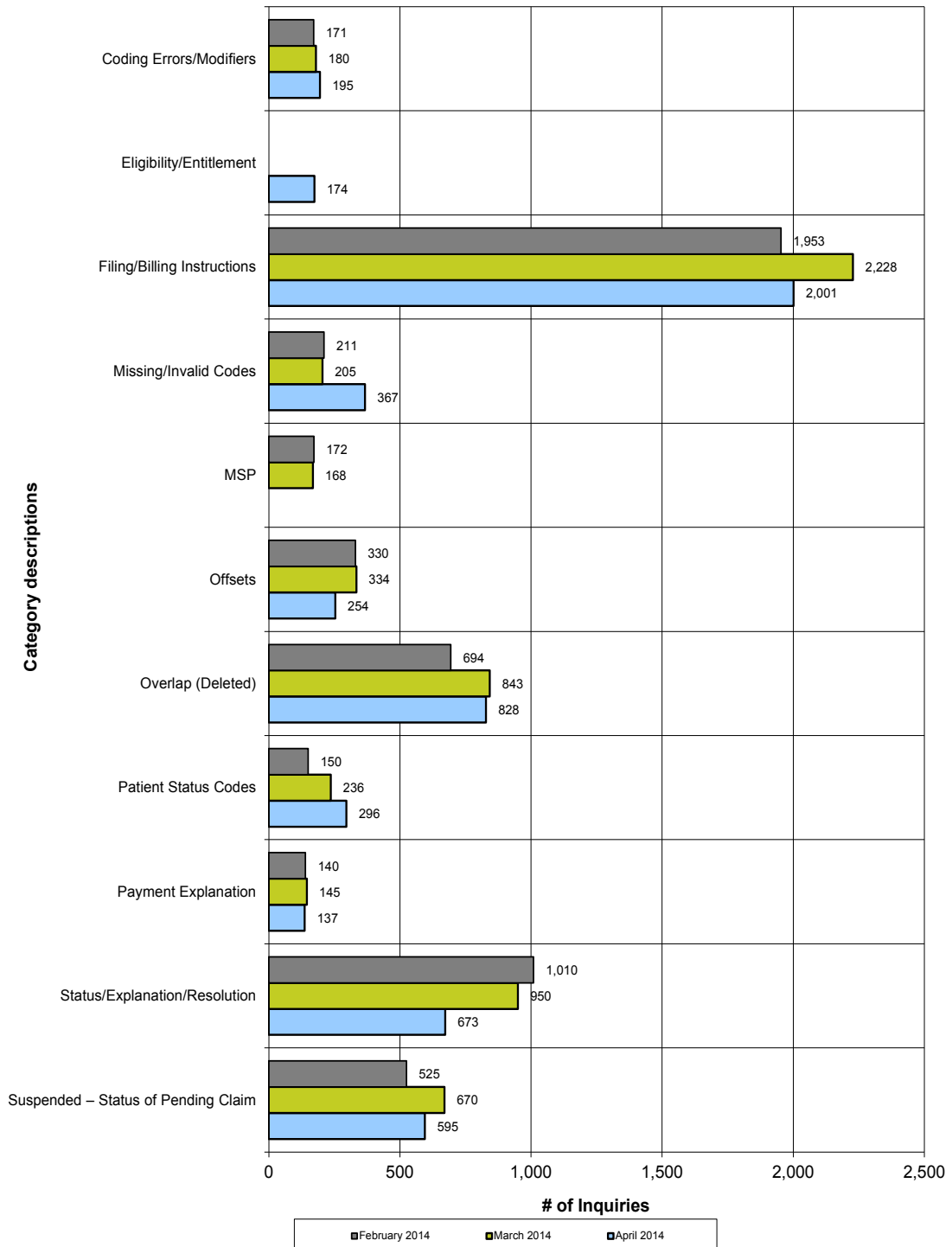
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during February 2014 through April 2014.

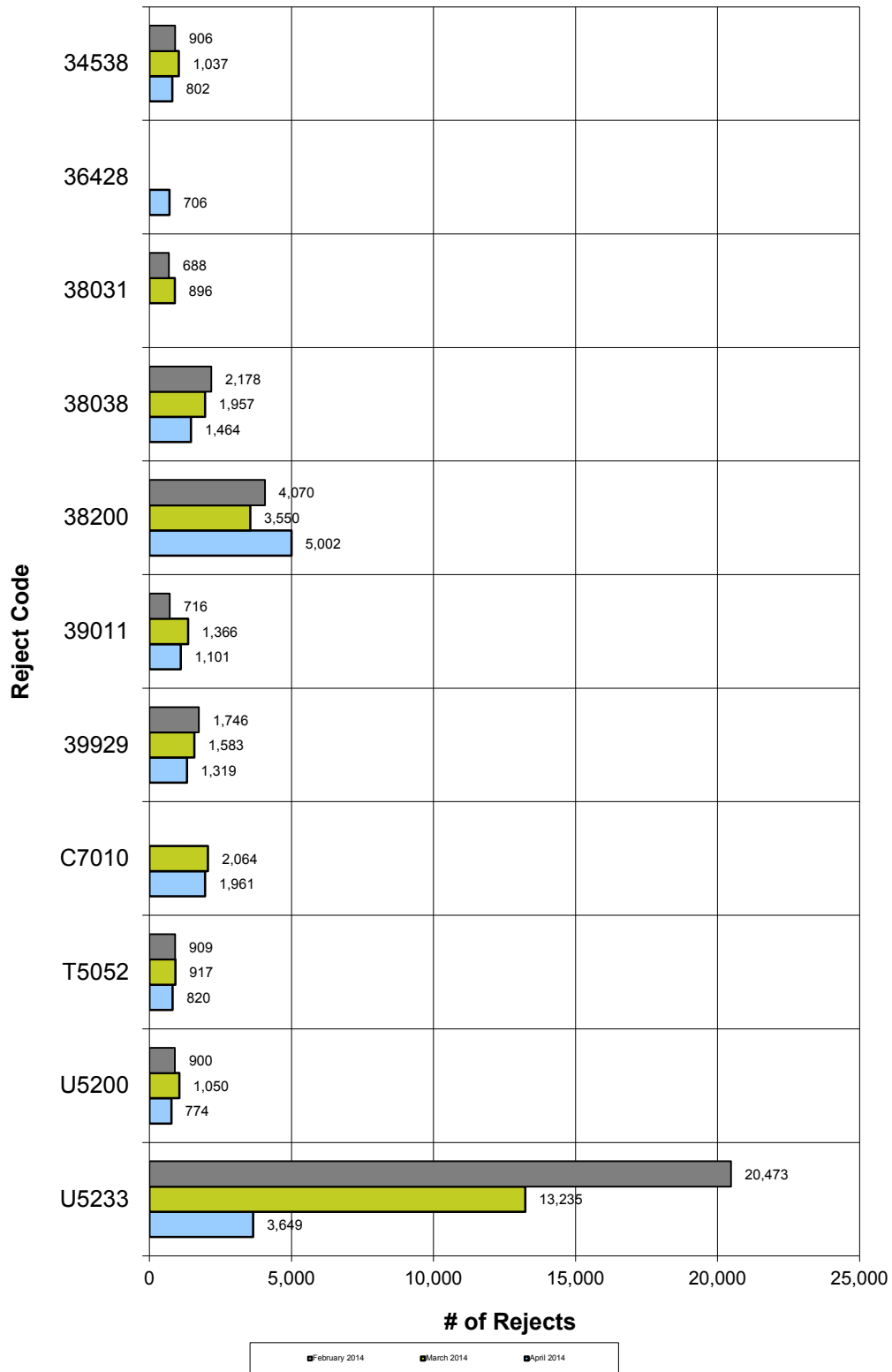
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Top inquiries for February-April 2014



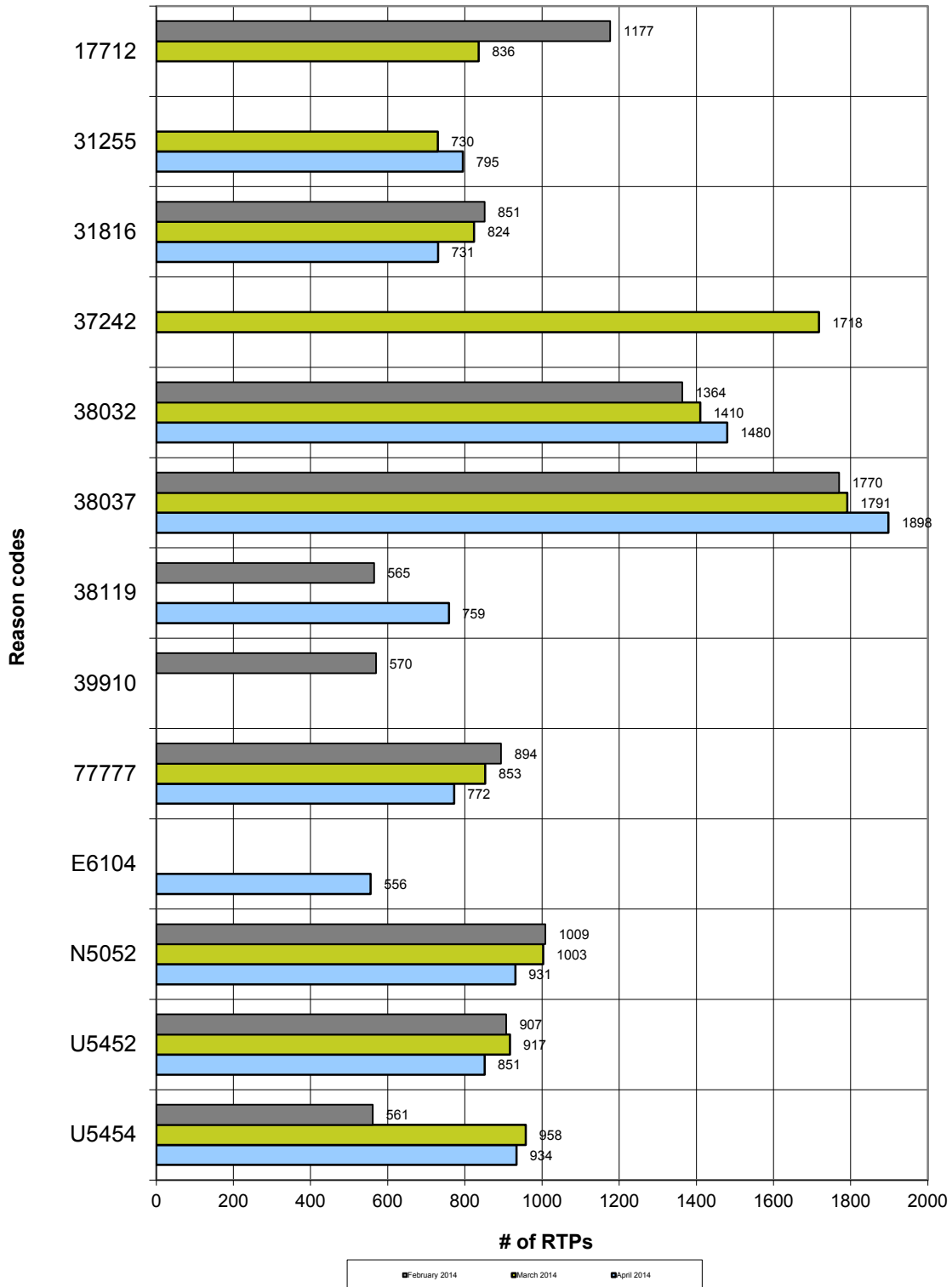
Part A top rejects for February 2014 through April 2014

Top rejects for February-April 2014



Part A top return to providers (RTPs) for February 2014 through April 2014

Top RTPs for February-April 2014



Reimbursement

Medicare physician fee schedule database April update

Note: This article was revised on May 16, 2014, to reflect the revised change request (CR) 8664 issued April 22. The article is revised to adjust Table 2 under “CR 8664 summary of changes” to clarify the effective dates for HCPCS code 77293 to be from January 1 to December 31, 2014. The CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the [April 2014 Medicare A Connection, Pages 27-29](#).

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (MACs), home health and hospices (HHHs), and/or regional HH intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 8664 which amends the payment files that were issued to Medicare contractors based upon the 2014 MPFS final rule and passage of the “Protecting Access to Medicare Act of 2014,” which the President signed April 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians’ services.

In order to reflect appropriate payment policy as included in the 2014 MPFS final rule, the MPFSDB has been updated with April changes, and those necessitated by “Protecting Access to Medicare Act of 2014,” which the President signed April 1, 2014. This law extends the 0.5 percent update through December 31, 2014. Since the Act extends the MPFSDB policies to all of 2014, the April update payment files that were previously created to be effective from January 1 to March 31, 2014, can now be used by MACs to be effective from January 1 to December 31, 2014.

Note: Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

CR 8664 summary of changes

The summary of changes for the April 2014 update consists of the following:

Table 1: Short description corrections for HCPCS codes G0416-G0419

HCPCS code	Old short description	Revised 2014 short description
G0416	Sat biopsy prostate 1-20 spc	Biopsy prostate 10-20 spc
G0417	Sat biopsy prostate 21-40	Biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60	Biopsy prostate 41-60
G0419	Sat biopsy prostate: >60	Biopsy prostate: >60

Table 2: Adjust the facility and non-facility PE RVUs for HCPCS code 77293 (global and TC) via CMS update files.

HCPCS	Mod	Status	Description	Non-facility PE RVUs	Facility PE RVUs	Global	Effective date
77293		A	Respirator motion mgmt simul	9.96	NA	ZZZ	Jan 1 to March 31, 2014
77293	TC	A	Respirator motion mgmt simul	9.16	NA	ZZZ	Jan 1 to March 31, 2014
77293		A	Respirator motion mgmt simul	10.72	NA	ZZZ	Correction April 1, 2014. RVU change effective January 1 to December 31, 2014.
77293	TC	A	Respirator motion mgmt simul	9.92	NA	ZZZ	Correction April 1, 2014. RVU change effective January 1 to December 31, 2014.

See MPFS, next page

MPFS

From previous page

Table 3: HCPCS code G9361 will be added to your Medicare contractor system.

Field	Indicator/descriptor
Status	M
Short descriptor	Doc comm risk calc
Effective date	01/01/2014
Work RVU	0
Full non-facility PE RVU	0
Full non-facility NA indicator	(blank)
Full facility PE RVU	0
Full facility NA indicator	(blank)
Malpractice RVU	0
Multiple procedure indicator	9
Bilateral surgery indicator	9
Assistant surgery indicator	9
Co-surgery indicator	9
Team surgery indicator	9
PC/TC	9
Site of service	9
Global surgery	XXX
Pre	0.00
Intra	0.00
Post	0.00
Physician supervision diagnostic indicator	09
Diagnostic family imaging indicator	99
Non-facility PE used for OPPS payment amount	0.00
Facility PE used for OPPS payment amount	0.00
MP used for OPPS payment amount	0.00
Type of service	9

Field	Indicator/descriptor
Long descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

Table 4: Correct physician supervision of diagnostic (Phys diag supv) procedures indicator for the TC's of the following codes, effective January 1, 2014.

HCPCS	Short descriptor	Phys diag supv	Effective date
70450 TC	CT head/brain w/o dye - phys diag supv correction (TC)	01	01/01/2014
70460 TC	CT head/brain w/dye - phys diag supv correction (TC)	02	01/01/2014
70551 TC	MRI brain stem w/o dye - phys diag supv correction (TC)	01	01/01/2014
70552 TC	MRI brain stem w/dye - phys diag supv correction (TC)	02	01/01/2014
70553 TC	MRI brain stem w/o & w/dye - phys diag supv correction (TC)	02	01/01/2014
72141 TC	MRI neck spine w/o dye - phys diag supv correction (TC)	01	01/01/2014

See **MPFS**, next page

MPFS

From previous page

HCPCS	Short descriptor	Phys diag supv	Effective date
72142 TC	MRI neck spine w/dye - phys diag supv correction (TC)	02	01/01/2014
72146 TC	MRI chest spine w/o dye - phys diag supv correction (TC)	01	01/01/2014
72147 TC	MRI chest spine w/dye - phys diag supv correction (TC)	02	01/01/2014
72148 TC	MRI lumbar spine w/o dye - phys diag supv correction (TC)	01	01/01/2014
72149 TC	MRI lumbar spine w/dye - phys diag supv correction (TC)	02	01/01/2014
72156 TC	MRI spine w/o & w/dye - phys diag supv correction (TC)	02	01/01/2014
72157 TC	MRI chest spine w/o & w/dye - phys diag supv correction (TC)	02	01/01/2014
72158 TC	MRI lumbar spine w/o & w/dye - phys diag supv correction (TC)	02	01/01/2014
72191 TC	CT angiograph pelv w/o&w/dye - phys diag supv correction (TC)	02	01/01/2014
74174 TC	CT angio abd&pelv w/o&w/dye - phys diag supv correction (TC)	02	01/01/2014

HCPCS	Short descriptor	Phys diag supv	Effective date
74175 TC	CT angio abdom w/o & w/dye - phys diag supv correction (TC)	02	01/01/2014
93880 TC	Extracranial bilat study - phys diag supv correction (TC)	01	01/01/2014
93882 TC	Extracranial uni/ltd study - phys diag supv correction (TC)	01	01/01/2014
77001 TC	Fluoroguide for vein device - phys diag supv correction (TC)	03	01/01/2014
77002 TC	Needle localization by xray - phys diag supv correction (TC)	03	01/01/2014
77003 TC	Fluoroguide for spine inject - phys diag supv correction (TC)	03	01/01/2014

Additional information

The official instruction, CR 8664, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2934CP.pdf>.

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work*.

MLN Matters® Number: MM8664 *Revised*
 Related Change Request (CR) #: CR 8664
 Related CR Release Date: April 22, 2014
 Effective Date: January 1, 2014
 Related CR Transmittal #:R2934CP
 Implementation Date: April 7, 2014

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Implementation of a prospective payment system for federally qualified health centers

Provider types affected

This *MLN Matters*[®] article is intended for federally qualified health centers (FQHCs) submitting claims to Part A Medicare administrative contractors (A MACs) for services furnished to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is establishing a federally qualified health center (FQHC) prospective payment system (PPS) with specific payment codes that FQHCs must use in order to ensure payment.

Change request (CR) 8743, from which this article is taken, implements the federally qualified health centers (FQHC) prospective payment system (PPS), effective for cost reporting periods beginning on or after October 1, 2014.

This article does not apply to any FQHC claims that are not subject to the PPS. FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014.

Make sure your billing staffs are aware of these new coding requirements.

Background

Except for services that are paid at 100 percent of costs, Medicare currently pays FQHCs 80 percent of their AIR. MACs reconcile costs and visits at year-end through cost report settlement.

In compliance with the statutory requirements of the Affordable Care Act, CMS established a national encounter-based prospective payment rate for all FQHCs, determined based on an average of the reasonable costs of all FQHCs.

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.



The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

From October 1, 2014, through December 31, 2015, the FQHC PPS base payment rate is \$158.85. Updates to the FQHC PPS base payment rate and the FQHC GAF will be made available through program instruction.

The FQHC PPS rates will be calculated as follows:

Base payment rate x FQHC GAF = PPS rate

If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate will be adjusted by 1.3416. This is a composite adjustment factor and would only be applied once per day. The PPS rate in this case would be calculated as follows:

Base payment rate x FQHC GAF x 1.3416 = PPS rate

To qualify for an encounter-based payment, a FQHC visit must meet all applicable coverage requirements. Additional information on the coverage requirements for FQHC visits can be found in the *Medicare Benefit Policy Manual*, Pub

See **FQHC**, next page

FQHC

From previous page

100-02, Chapter 13, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

FQHC specific payment codes

CMS is establishing five specific payment codes to be used by FQHCs submitting claims under the PPS:

1. G0466 – FQHC visit, new patient

A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

2. G0467 – FQHC visit, established patient

A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

3. G0468 – FQHC visit, IPPE or AWW

A FQHC visit that includes an IPPE or AWW and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWW.

4. G0469– FQHC visit, mental health, new patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

5. G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other

paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

Basic billing requirements

When reporting an encounter/visit for payment, the claim (77x TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469 or G0470) that corresponds to the type of visit.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052x or under revenue code 0519. **Note:** Revenue code 0519 is only used for Medicare Advantage (MA) supplemental claims.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must continue to report detailed HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit.

See Attachment A of CR 8743 for a list of qualifying visits that correspond to the specific payment codes. (**Note:** A link to CR 8743 is available in the *Additional information* section at the end of this article.)

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

When submitting a claim for a subsequent illness or injury, FQHCs must report the appropriate specific payment code (G0467 for a medical visit or G0470 for a mental health visit) with modifier 59.

Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit).

Note: A qualifying visit is still required when reporting modifier 59 with G0467 or G0470.

FQHCs must report all services that occurred on the same
See **FQHC**, next page

FQHC

From previous page
day on one claim.

FQHC may submit claims that span multiple days of service. However, FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid based on the AIR. MACs shall reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC's cost reporting period.

Durable medical equipment (DME), laboratory services (excluding 36415), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected.

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services are subject to the frequency edits described in Pub 100-04, Chapter 18, and should not be reported on the same day.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

Please refer to the examples in Attachment B of CR 8743 for additional billing guidance.

Medicare payment

The total payment amount for a FQHC visit shall be the lesser of the FQHC's reported charge for the FQHC payment code or the fully adjusted FQHC PPS rate for the specific payment code. Under the FQHC PPS, MACs shall generally pay 80 percent of the lesser of the FQHC's charge for the FQHC payment code or the corresponding FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the FQHC PPS rate.

Medicare waives coinsurance for certain preventive services. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, MACs shall pay 100 percent of the lesser of the provider's charge for the FQHC payment code or the FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For FQHC claims that include a mix of preventive and non-preventive services, MACs shall use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount.

To determine the amount of Medicare payment and the amount of coinsurance that should be waived, MACs shall

use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount.

(See the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 18, Section 1.2, for a table of preventive services that are exempt from beneficiary coinsurance. That manual chapter is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>.)

Claims for Medicare Advantage (MA) supplemental payments

FQHCs that have a written contract with a MA organization that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that is specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary.

The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. To facilitate accurate payment, claims for MA supplemental payments under the FQHC PPS must include the specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

Additional information

The official instruction, CR 8743, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1383OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work*.

MLN Matters® Number: MM8743
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Related CR Release Date: May 9, 2014
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Related CR Transmittal #: R1383OTN
Implementation Date: October 6, 2014

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July 2014 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs), and/or home health and hospices (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

MACs will use the July 2014 average sales price (ASP) and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2014, with dates of service July 1, 2014, through September 30, 2014.

CR 8748, from which this article is taken, instructs MACs to implement the July 2014 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised April 2014, January 2014, October 2013, and July 2013 ASP drug pricing files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies the MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4, Section 50 (Outpatient PRICER)) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.

The following table shows how the quarterly payment files will be applied:

Files	Effective for dates of service
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013

Additional information

The official instruction, CR 8748 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2936CP.pdf>.

MLN Matters® Number: MM8748
 Related Change Request (CR) #: CR 8748
 Related CR Release Date: April 25, 2014
 Effective Date: July 1, 2014
 Related CR Transmittal #: R2936CP
 Implementation Date: July 7, 2014

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Hospitals

New and renamed fields in the inpatient hospital provider specific file and the inpatient pricer output

Note: This article was revised April 24, 2014, to reflect the revised change request (CR) 8546 issued April 17, 2014. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8546 are revised. All other information remains the same. This article was previously published in the February 2014 issue of *Medicare A Connection*, Page 59-60.

Provider types affected

This *MLN Matters*[®] article is intended for providers and suppliers submitting institutional claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on CR 8546 which informs MACs about changes to the PSF. The PSF is maintained by MACs to facilitate proper payments to providers.

Note: CR 8546 is not implementing the hospital acquired condition (HAC) reduction program initiative or the electronic health records (EHR) incentive program, but is only preparing the Centers for Medicare & Medicaid Services (CMS) systems for the future.

Specific instructions implementing these programs, including manual updates to Addendum A of the *Medicare Claims Processing Manual* will be issued in the future in the event these policies are finalized. Make sure that your billing staffs are aware of these changes.

Background

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay.

Under the HAC reduction program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the inpatient prospective payment system (IPPS). Section 3133 of the Affordable Care Act provides for an additional payment for a hospital's uncompensated care.

Each Medicare disproportionate-share (DSH) hospital will receive an uncompensated care payment (UCP) based on its share of uncompensated care as calculated by CMS for Medicare DSH hospitals. Currently, for FY 2014, the estimated per claim UCP amount is stored in pricer. In order to make changes to the amounts more efficient,



CMS is adding the estimated per claim UCP amount to the PSF.

The Medicare EHR incentive program provides incentive payments for eligible acute-care inpatient hospitals that are meaningful users of certified EHR technology. Eligible-acute care inpatient hospitals are defined as “subsection (d) hospitals”— which are generally hospitals that are paid under the IPPS and are located in one of the 50 states or the District of Columbia.

Hospitals that are not meaningful users of certified EHR technology will be subject to payment adjustments beginning in FY 2015. Model 1 of the bundled payments for care improvement (BPCI) initiative provides a discounted payment to Model 1 participating hospitals for the acute-care hospital stay. The discount will be phased in over the performance period of three years.

To accommodate the 0.5 percent discount for months seven to 12, the Model 1 discount percentage field in the PSF must be expanded.

Summary of CR 8546 changes

The inpatient PSF will be expanded to include three new fields and an expansion of the existing Model 1 discount percentage field as follows:

1. Add an indicator for hospitals subject to the hospital acquired conditions (HAC) reduction program for future implementation.

See **INPATIENT**, next page

INPATIENT

From previous page

2. Add an estimated interim per claim uncompensated care payment amount.
3. Add an indicator for hospitals subject to an electronic health records incentive program reduction for future implementation.
4. Expand the existing 2-byte Model 1 discount percentage field to three-bytes.

In order to avoid confusion with the four new payment amount fields created in CR 8217, we are renaming them here. In addition, we are redefining existing filler in the output record PRICER returns to Fiscal Intermediary Standard System (FISS) to accommodate future policy and/or legislative changes that might require system changes.

The new fields are:

- PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02).
- PPS-FLX5- PAYMENT PIC S9(07)V9(02).
- PPS-FLX6- PAYMENT PIC S9(07)V9(02)
- PPS-FLX7- PAYMENT PIC S9(07)V9(02).

The renamed fields are:

- From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT
- From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT
- From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT
- From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT

Additional information

The official instruction, CR 8546 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2933CP.pdf>.

MLN Matters® Number: MM8546 Revised
 Related Change Request (CR) #: CR 8546
 Related CR Release Date: April 17, 2014
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 Implementation Date: July 7, 2014

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Instructions for incorporating GME caps in cost reports

Section 5506 of the Affordable Care Act directed the Centers for Medicare & Medicaid Services to develop a process to permanently preserve and redistribute the Medicare funded residency slots from teaching hospitals that close.

Priority is given to hospitals located in the same or contiguous core-based statistical area (CBSA) as the closed hospital.

Change request (CR) 8633 provides instructions to Medicare administrative contractors for incorporating the

section 5506 cap increases that are effective retroactively on applicable hospitals' cost reports that have already been filed, and for recalculating the hospital's direct graduate medical education (GME) and indirect medical education (IME) payments accordingly on those already filed cost reports, 2) to provide hospitals with instructions for incorporating Round 1, or Round 2, or Round 3 and subsequent rounds of section 5506 cap increases into cost reports that have not yet been filed.

Details are available *in CR 8633 on the CMS website*. A full copy of CR 8633 is also available in [Appendix A](#).

Inpatient psychiatric facility claims teaching adjustments not displaying correctly

Due to a software issue in the October 2013 release of the inpatient psychiatric facility (IPF) pricer, the teaching adjustment amounts on IPF claims have not been displaying in the value code 19 field.

Please note: This has not impacted the total payment amount on the claims, as teaching adjustment amounts were included.

Medicare administrative contractors (MACs) will complete mass adjustments to all IPF claims with a teaching adjustment, for discharge dates on or after October 1, 2013, within 90 days of the second release of the October 2013 IPF pricer that will be installed into production on or after July 7, 2014.

Anesthesiologist/certified registered nurse anesthetist related services in a method II critical access hospital

Provider types affected

This *MLN Matters*® article is intended for anesthesiologists and certified registered nurse anesthetists (CRNAs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8708, which clarifies the payment for reasonable and necessary medical or surgical services performed by an anesthesiologist or CRNA in a method II critical access hospital (CAH). Make sure your billing staffs are aware of this clarification.

Background

Anesthesiologists and CRNAs rendering services in a method II CAH (also referred to as CAHs that have elected the optional method) have the option of reassigning their billing rights to the CAH. When billing rights are reassigned, the method II CAH submits an 85x bill type with revenue code 0963 (professional fees for anesthesiologist (MD)) or revenue code 0964 (CRNA Professional Services) for payment for anesthesia or related services.

Method II CAHs are eligible to receive reimbursement for any services that the CRNA is legally authorized to perform in the state in which the services are furnished. Method II CAHs are eligible to receive reimbursement for reasonable, medically necessary or surgical services when performed by an anesthesiologist.

Currently, the only procedures performed by a CRNA or an anesthesiologist that are eligible for method II reimbursement are Healthcare Common Procedure Coding System (HCPCS) codes 00100-01999 billed with revenue code 0963 and/or 0964 on bill type of 85x.

The purpose of CR 8708 is to allow, effective for dates of service on or after January 1, 2013, for payment for eligible CRNA services in a method II CAH and submitted on the 85x bill with revenue code 0964.

Similarly, effective for services on or after January 1, 2014, the MACs will allow for services performed by an anesthesiologist submitted by a method II CAH on bill type 85x with revenue code of 0963.



If you had claims incorrectly processed prior to implementation of CR 8708, your MAC will adjust those claims if you bring them to the MAC's attention.

Additional Information

The official instruction, CR 8708, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1379OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - *How does it work*.

MLN Matters® Number: MM8708
 Related Change Request (CR) #: CR 8708
 Related CR Release Date: May 2, 2014
 Effective Date: January 1, 2013
 Related CR Transmittal #: R1379OTN
 Implementation Date: October 6, 2014

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Educational Events

Provider outreach and educational events June 2014

Medicare Part A changes and regulations

When: Tuesday, June 24
Time: 1:30 p.m. - 3:30 p.m. ET – Delivery language: English
Type of Event: Webcast
<http://medicare.fcso.com/Events/267483.asp>

Advance beneficiary notice of non-coverage

When: Tuesday, June 24
Time: 1:00 p.m. - 2:30 p.m. ET – Delivery language: English
Type of Event: Webcast
<http://medicare.fcso.com/Events/269756.asp>

Two easy ways to register

- Online** – Visit www.fcsouniversity.com, logon to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event. **First-time user?** Set up an account by completing “Request a New Account” online. Providers with no national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.
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Registrant’s Title: _____

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Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at www.fcsouniversity.com.



CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*™ Provider eNews is an official *Medicare Learning Network*® (MLN) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- CMS MLN Connects™ Provider eNews: May 1, 2014 – <http://go.usa.gov/k7hh>
- CMS MLN Connects™ Provider eNews: May 8, 2014 – <http://go.usa.gov/kSd5>
- CMS MLN Connects™ Provider eNews: May 15, 2014 – <http://go.usa.gov/843H>
- CMS MLN Connects™ Provider eNews: May 22, 2014 – <http://go.cms.gov/1jVHzTn>

Medicare billing certificate programs

Earn a certificate in Medicare billing for either Part A or Part B billing from the Centers for Medicare & Medicaid Services (CMS).

The programs are designed to provide education on Part A and Part B of the Medicare program. They each include required Web-based training courses, readings, and a list of helpful resources.

Upon successful completion of each of the programs, you will receive a certificate in Medicare billing from CMS.

To participate in either the Part A or Part B provider type

program, visit <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html> and select *Web-Based Training (WBT) Courses*.

- From the list of courses, select the Medicare billing certificate program for your provider type.
- Login (continuing user) or register (new user) by clicking on the links at the top of the *Course* screen.
- On the next screen choose *Web-Based Training Courses* and reselect your course.
- Click the *Take Course* button and begin.

Medicare Speaks – Fort Lauderdale July 22-23

Fort Lauderdale Marriott North, 6650 North Andrews Avenue, Fort Lauderdale, FL 33309

Learn what’s trending now in Medicare by joining First Coast Service Options (First Coast) for Medicare Speaks, July 22-23, 2014, in Fort Lauderdale, FL.

The event features 20 classes focused on reducing documentation and claim errors, and minimizing payment delays. First Coast is also offering seminars on July 21 on PC-ACE Pro32™; Medicare’s free billing software and the Centers for Medicare & Medicaid Services (CMS) initiative the physician quality reporting system (PQRS) program.

Participants will benefit from data-driven content based on the latest Medicare changes that you need to know to bill Medicare the right way, the first time. Best of all, providers can interact with their peers as well as Medicare experts from First Coast.

Highlights

- [20 Part A and B classes chosen by your peers – view agenda](#)

- Participation from First Coast’s medical director and leaders from Medical Review, Provider Enrollment, Customer Service and Provider Outreach and Education departments
- Seminar on July 21 regarding PC-ACE Pro32™ and PQRS program
- Participants can select four classes per day, or tailor the schedule to meet your needs
- Medicare experts available to answer your questions at *Ask the Contractor* tables
- Continuing education credits offered

For additional information regarding the event, including logistics and registration, view our [Medicare Speaks 2014 Fort Lauderdale](#) brochure.

[Register now](#)

Note: If you do not have a training account, please click here to learn how to create one.

Florida/USVI addresses

First Coast Service Options

American Diabetes Association certificates

Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Claims/correspondence

Florida:

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:

First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing

Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse

Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

(relative to cost reports and audits)

Provider Audit and Reimbursement (PAR)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations

Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)

General information, conditional payment

Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits

MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities

Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections

Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review

First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment

CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination

Florida:

Medicare Part A Redetermination/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

U.S. Virgin Islands:

First Coast Service Options Inc.
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail & courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)

DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare

Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary

Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Florida/USVI phone numbers

Customer service/IVR

Providers:

888-664-4112

Speech and hearing impaired

877-660-1759

Beneficiaries:

800-MEDICARE (800-633-4227)

Speech and hearing impaired

800-754-7820

Credit balance report

Debt recovery

904-791-6281

Fax

904-361-0359

Electronic data interchange

888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement

904-791-8430

Provider education and outreach

Seminar registration hotline

904-791-8103

Seminar registration fax

904-361-0407

Provider enrollment

877-602-8816

Websites

First Coast Service Options Inc.
(Florida, U.S. Virgin Islands Medicare contractor)

medicare.fcso.com

Centers for Medicare & Medicaid Services

Providers:

www.cms.gov

Beneficiaries:

www.medicare.gov

Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is:

ROATLFM@CMS.HHS.GOV

Puerto Rico addresses

Claims

Additional documentation General mailing Congressmen mailing

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

Redeterminations on overpayments

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

Credit balance

First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Audit and reimbursement department

Reporte de costo, auditoría,
apelación de reporte de costo,
porcentaje tentativo, rama de PS &R

First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary

Palmetto Government Benefit
Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare

Palmetto Government Benefit
Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Puerto Rico phone numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

**For the hearing and speech impaired
(TDD)**
1-888-216-8261

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

**For the hearing and speech impaired
(TDD)**
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number

1-904-361-0407

Audit And Reimbursement Department

Fax number 1-904-361-0407

Websites

Providers

First Coast – MAC J9

medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services

www.medicare.gov

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1371	Date: April 18, 2014
	Change Request 8633

SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA) - Preservation of Resident Cap Positions from Closed Teaching Hospitals – Rounds 1, 2, 3 and After

I. SUMMARY OF CHANGES: Section 5506 of the ACA directed CMS to develop a process to preserve the FTE (full-time equivalent) resident caps from teaching hospitals that close. On January 31, 2013, CMS issued **CR7746, Pub.100-20, R1171OTN.pdf, R1171_OTN1.xlsx, “Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only”**. CMS is now issuing this subsequent CR to address section 5506 Rounds 1, 2, 3, and subsequent rounds.

EFFECTIVE DATE: May 19, 2014

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

IMPLEMENTATION DATE May 19, 2014

- 30 days from issuance, as part of the normal settlement process

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
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1371	Date: April 18, 2014	Change Request: 8633
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SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA) - Preservation of Resident Cap Positions from Closed Teaching Hospitals – Rounds 1, 2, 3 and After

EFFECTIVE DATE: May 19, 2014

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

IMPLEMENTATION DATE: May 19, 2014

- 30 days from issuance, as part of the normal settlement process

I. GENERAL INFORMATION

A. Background: Section 5506 of the ACA directed CMS to develop a process to preserve the FTE (full-time equivalent) resident caps from teaching hospitals that close. CMS finalized its policy for implementing section 5506, which included establishment of an application process and procedures for redistributing the FTE resident cap slots associated with the closed hospital's direct GME and IME caps, in the November 24, 2010 Federal Register (75 FR 72212). On January 31, 2013, CMS issued **CR7746, Pub.100-20, R1171OTN.pdf, R1171_OTN1.xlsx, "Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only"**. The rules for redistributing and implementing redistributed cap positions from closed teaching hospitals under Rounds 1 and 2 of section 5506 were based on the policy established in the November 24, 2010 Federal Register (75 FR 72225-6), and further clarified in the August 31, 2012 Federal Register (77 FR 53434-53447).

However, in the August 31, 2012 Federal Register (77 FR 53434-53447), CMS revised some parts of the policy related to section 5506, applicable to Round 3 and subsequent rounds of section 5506. On Jan 30, 2013, CMS posted on its website the awards from Round 3 for hospitals that received slots due to the closures of Hawaii Medical Center East, Oak Forest Hospital, and Huron Hospital. On January 30, 2014, CMS posted on its website the awards from Round 4 (associated with slots due to the closure of Peninsula Hospital Center) and from Round 5 (associated with slots due to the closure of Infirmiry West Hospital and Montgomery Hospital). To see the awardees, the awards, and the effective dates, go to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>, and select the link for "Section 5506 Cap Increases Round 3," or "Section 5506 Cap Increases Round 4," or "Section 5506 Cap Increases Round 5," respectively.

Based on the policy established in the November 24, 2010 Federal Register (75 FR 72225-6), and further clarified in the August 31, 2012 Federal Register (77 FR 53437-53443), the additional cap slots that a hospital receives under section 5506 may have different effective dates. That is, of the total cap slots that a qualifying hospital receives, some slots may increase the FTE resident cap retroactively to the date of a particular hospital closure, some slots are tied to the graduation dates of particular displaced residents, while other cap slots would only become effective after a hospital can demonstrate to its Medicare contractor that it has actually filled those slots, and therefore, additional cap slots are needed. CMS is not requiring hospitals to file amended cost reports to incorporate section 5506 cap increases that are effective retroactively and affect cost reports that have already been filed. Instead, the contractors will revise the applicable hospitals' cost reports. There are two purposes of this CR: 1) to provide instructions to the contractors for incorporating the section 5506 cap increases *that are effective retroactively* on applicable hospitals' cost reports *that have already been filed*, and for recalculating the hospital's direct GME and IME payments accordingly on those already filed cost reports, 2) to provide hospitals with instructions for incorporating Round 1, or Round 2, or Round 3 and subsequent rounds of section 5506 cap increases into

cost reports that have not yet been filed.

NOTE: For hospitals that received FTE resident cap increases under Round 1 and/or Round 2, use CR7746, Pub.100-20, R1171OTN.pdf, “Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only”. For hospitals that received FTE resident cap increases under Round 1 and/or Round 2, and Round 3 or a subsequent Round, use this CR 8633. For hospitals that received or receive FTE resident cap increases only under Round 3 or a subsequent Round, also use this CR 8633, in order to properly determine, track, and record on the cost reports the FTE resident cap increases and payments associated with section 5506 of the ACA.

B. Policy: In the August 31, 2012 IPPS Federal Register [77 FR 53437-5344], CMS clarified and modified the effective dates of eight Ranking Criteria under which hospitals’ applications for slots from closed hospitals are ranked. (Under the original policy applicable to Rounds 1 and 2 established in the November 24, 2010 Federal Register, there were seven Ranking Criteria). Slots are redistributed to applying hospitals based, in part, on these eight Ranking Criteria, with a higher-ranked application receiving slots before a lower-ranked application. For hospitals receiving slots under Ranking Criteria 1 or 3, the permanent cap increase is tied to particular displaced residents, and the effective date is the day after the graduation date(s) of actual displaced resident(s), which may be associated with past or subsequent cost reports. For hospitals receiving slots under Ranking Criterion 2, the permanent cap increase is effective on the day of a particular hospital’s closure (77 FR 53443 August 31, 2012), which would always be associated with a past cost reporting period. For hospitals receiving slots under Ranking Criteria 4, 5, 6, 7, or 8, the permanent cap increases are effective the later of when a hospital can demonstrate to the Medicare contractor that the slots associated with a new program or program expansion are actually filled, and therefore, are needed as of a particular date (usually July 1, possibly retroactive), or the July 1 *after* displaced residents complete their training. (For Ranking Criterion 8, if the award is for cap relief, the effective date is the date of the CMS award announcement, or the July 1 *after* displaced residents complete their training, whichever is later). Following are instructions in Attachment 2 for contractors on how to amend hospitals’ applicable submitted cost reports to reflect the change in direct GME and IME payment due to the FTE resident cap increases received under Round 3 and subsequent rounds of section 5506, and instructions for providers on how to report the FTE counts of cost reports that have not yet been submitted.

Note that contractors may be amending several cost reports for each applicable hospital; that is, the hospital’s FYs 2010, 2011, 2012, and possibly 2013 cost reports, depending on the hospital’s fiscal year end. Also note that separate instructions are provided in Attachment 2 for amending cost reports filed on the CMS Form 2552-96 and on the CMS Form 2552-10. This is because worksheet E, Part A and worksheet E-3, Part IV on the CMS Form 2552-96 were not revised, and will not be revised, to incorporate lines to report the section 5506 FTE resident cap increases. However, worksheet E, Part A and worksheet E-4 of the CMS Form 2552-10 were amended to accommodate the section 5506 FTE resident cap increases. Therefore, the instructions for amending a cost report and reporting the section 5506 FTE resident cap increase will differ depending on whether the applicable cost report is filed on the CMS Form 2552-96 or the CMS Form 2552-10.

Contractors and hospitals shall use the excel spreadsheet called CR 8633 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase. The 3rd and 4th tabs of that spreadsheet may be used to record and track all of a hospital’s section 5506 cap adjustments and their effective dates (even for subsequent section 5506 rounds). **C. Interaction of the 3-Year Rolling Average and Slots Awarded Under Section 5506 (Applicable to CMS Form 2552-96 and CMS Form 2552-10):**

As a hospital’s FTE resident cap increases as a result of section 5506 awarded slots, the hospital is able to count more FTE residents for IME and direct GME payment purposes on a cost report. The higher allowable current year FTE count also means that a larger FTE count would be incorporated into the rolling average

calculation and into the IME intern and resident-to-bed (IRB) ratio cap. If a hospital received a section 5506 award, but did not also receive a temporary cap adjustment for displaced residents under section 413.79(h), then the additional FTEs counted are immediately subject to the rolling average and the IRB ratio cap. Under the policy applicable to Round 3 and subsequent rounds, (which differs from the policy associated with Rounds 1 and 2), the cap awards do not even take effect until residents displaced from the applicable closed hospital have graduated (see chart at 77 FR 53443 August 31, 2012). Furthermore, FTEs added and associated with awards under Ranking Criteria 2, or 4 through 8 would immediately be subject to the rolling average. For a hospital that did receive a temporary FTE cap adjustment and an attending exemption from the rolling average under section 413.79(h) for training residents displaced from a closed hospital, the following describes when and how section 5506 slots would replace the temporary cap adjustments of displaced FTE residents, resulting in the inclusion of the displaced FTEs in the rolling average and subjection to the IME IRB ratio cap:

Separation of Awards from Round 1 and Round 2:

As stated under CR 7746, slots awarded under Round 1 may only replace temporary FTE cap adjustments associated with residents displaced from Round 1. If in a cost reporting period, a hospital is awarded slots from Round 1 and is training FTEs displaced both by the closed hospitals associated with Round 1 and with the closed hospital associated with Round 2, the slots awarded under Round 1 would not remove Round 2 displaced FTEs from exemption from the rolling average. Only slots awarded from Round 2 may remove FTEs from being reported after the rolling average. Similarly, slots awarded under Round 2 would not remove Round 1 displaced FTEs from exemption from the rolling average. Furthermore, no slots awarded under Round 1 or Round 2 may replace residents displaced by the closure of other unrelated individual programs or hospitals that were not part of Round 1 or Round 2 (such as the closure in New York of Brookdale University Hospital Medical Center's anesthesiology program or the closure of Peninsula Hospital Center). If a hospital received a temporary cap adjustment under section 413.79(h) for residents displaced from another closed program or hospital not associated with Round 1 or Round 2, those displaced FTEs would continue to be exempt from the rolling average and the IRB ratio cap, so long as the hospital qualifies for a temporary cap adjustment (i.e., the hospital's total allopathic and osteopathic FTE count including FTEs from all program or hospital closures is greater than the hospital's FTE resident cap *with* the usual adjustments (including section 5503 or section 5506 adjustments)). Specifically, under Round 3 and after, because the cap awards do not even take effect until residents displaced from the applicable closed hospital have graduated, there is no issue of a Round 3 award "wiping out" an exemption from the rolling average for residents displaced by the closure of the hospital associated with Round 3. Therefore, any displaced FTEs that a hospital may be training would only be exempt from the rolling average and the IRB ratio cap if the hospital's total allopathic and osteopathic FTE count including FTEs from all program or hospital closures is *greater than* the hospital's FTE resident cap *with* the applicable adjustments (including section 5503 or section 5506 adjustments)).

Refer to Attachment 2 for Instructions on how to complete the excel spreadsheet CR 8633 5506 Temp Adj Calc.xlsx. Two examples are included in Attachment 2 to provide guidance on completing CR 8633 5506 Temp Adj Calc.xlsx. Attachment 2 also contains instructions for the steps to report the FTE caps and counts to report on the Medicare cost report.

II. Timeframe for Implementation

Contractors shall complete the business requirements in this CR as part of the normal settlement and reopening processes. If the SSI ratios for a fiscal year are not available, those cost reports that are impacted by CR 7746 and this CR 8633 shall not be settled.

Once a hospital's CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).

At this point, we are not instructing contractors to issue revised tentative settlements on any open cost reports for any cost report revisions made pursuant to this CR resulting in additional monies due to the hospitals. However, if an extended period of time occurs between proposing the adjustments to incorporate the DGME and/or IME cap increases and the final settlement of the cost report, contractors may consider issuing a subsequent tentative settlement.

Contractors shall use the provider’s IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared-System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
8633.1	Contractors shall refer to the hospital’s section 5506 award letter or CMS website (go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html , and in the Downloads section of the page, click on the appropriate Round of Section 5506 Cap Increases to identify any cap increases that are effective during cost reports that have already been filed.	X									
8633.2	Contractors and hospitals shall use the excel spreadsheet called CR 8633 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase.	X									
8633.3	Contractors shall use this CR 8633 to amend and incorporate the section 5506 cap increases <i>that are effective retroactively</i> on applicable hospitals’ cost reports <i>that have already been filed</i> , and for recalculating the hospital’s direct GME and IME payments accordingly on those already filed cost reports.	X									
8633.4	For hospitals that received FTE resident cap increases under Round 1 and/or Round 2, contractors shall use CR7746, Pub.100-20, R1171OTN.pdf, “Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only”. For hospitals that received FTE resident cap increases under Round 1 and/or Round 2, and Round 3 or a subsequent Round,	X									

Number	Requirement	Responsibility									
		A/B MAC		D M E M A C	Shared- System Maintainers				Other		
		A	B		H H H	F I S S	M C S	V M S		C W F	
	contractors shall use this CR 8633. For hospitals that received or receive FTE resident cap increases only under Round 3 or a subsequent Round, contractors shall also use this CR 8633, in order to properly determine, track, and record on the cost reports the FTE resident cap increases and payments associated with section 5506 of the ACA.										
8633.5	Contractors shall complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx for all hospitals that received a section 5506 cap award(s), from any round of section 5506, past or future, even if the hospital did not train displaced residents in this cost reporting period. Contractors shall complete Tab 1 and possibly Tab 2 of CR 8633 Section 5506 Temp Adj Calc.xlsx if the hospital is training displaced residents in this cost reporting period.	X									
8633.6	Contractors shall refer to Attachment 2 of this CR 8633 for detailed instructions on completing CR 8633 Section 5506 Temp Adj Calc.xlsx and worksheets E, Part A, E-3, Part IV, and E-4, and for determining whether a hospital may receive a temporary cap adjustment under 42 CFR 413.79(h) for displaced FTE residents. Contractors shall ask a hospital to provide any FTE information for IME and for direct GME respectively (including unweighted, weighted, and displaced FTE information) that the contractor requires in order to implement this CR 8633.	X									
8633.7	Contractors shall determine if the hospital’s cost report was filed on CMS Form 2552-96 of CMS Form 2552-10. If it was filed on CMS Form 2552-10, then skip to the applicable business requirement below.	X									
8633.8	If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	X									
8633.9	If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the	X									

Number	Requirement	Responsibility								Other
		A/B MAC		D M E M A C	Shared- System Maintainers					
		A	B		H H H	F I S S	M C S	V M S	C W F	
	contractor shall incorporate the applicable steps in this CR into the desk review.									
8633.10	If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall complete the applicable steps in this CR before settling the cost report.	X								
8633.11	<u>For Form 2552-96 Cost Reports:</u> Contractors shall report the amount of the section 5506 cap increase for IME and/or direct GME respectively that <i>is effective during the cost report that contractors are amending</i> on worksheet S-3, Part I, line 17. Contractors shall use column 7 for the IME cap increase and column 8 for the direct GME cap increase.	X								
8633.12	<u>IME:</u> On worksheet E, Part A, line 3.06, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. Contractors shall proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital's IME payment on that cost report.	X								
8633.13	<u>Direct GME:</u> On worksheet E-3, Part IV, line 3.03, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. Contractors shall proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital's direct GME payment on that cost report.	X								
8633.14	<u>For Form 2552-10 Cost Reports:</u> If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	X								
8633.15	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as	X								

Number	Requirement	Responsibility									
		A/B MAC		D M E M A C	Shared- System Maintainers				Other		
		A	B		H H H	F I S S	M C S	V M S		C W F	
	of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall incorporate the applicable steps in this CR into the desk review.										
8633.16	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall complete the applicable steps in this CR before settling the cost report.	X									
8633.17	<u>IME</u> : Contractors shall report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 <i>applicable to this cost reporting period</i> , and proceed through the rest of Worksheet E, Part A, making revisions as necessary. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the website and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscribed to report slots awarded from <i>different</i> rounds of section 5506; that is, from different CMS application processes.	X									
8633.18	<u>Direct GME</u> : Contractors shall report the amount of the section 5506 cap increase for direct GME on worksheet E-4, line 4.02 <i>applicable to this cost reporting period</i> , and proceed through the rest of Worksheet E-4, making revisions as necessary. The number of times line 4.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the website and the number of award letters the hospital receives for each respective round. Line 4.02 shall only be subscribed to report slots awarded from <i>different</i> rounds of section 5506; that is, from different CMS application processes.	X									
8633.19	Contractors shall complete the business requirements in this CR as part of the normal settlement and reopening processes. If the SSI ratios for a fiscal year are not available, those cost reports that are impacted by CR 7746 and this CR 8633 shall not be settled.	X									
8633.20	Once a hospital's CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a	X									

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H		F M V C	I C M W	S S S F		
	revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).									
8633.21	Contractors shall use the provider's IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		
8633.22	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Miechal Lefkowitz, 212-616-2517 or miechal.lefkowitz@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment(s)

Attachment – One-Time Notification, CR 8633

I. Instructions for Completing the Excel Spreadsheet Tabs

Refer to CR 8633 Section 5506 Temp Adj Calc.xlsx that is provided with this CR. There are 4 Tabs on this excel spreadsheet, to be completed as follows:

- 1) For All Hospitals that Received Section 5506 Cap Awards, Under Any Round of Section 5506: Refer to the CMS website (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html>) or the hospital’s section 5506 award letter to identify any cap increases that are effective during cost reports that have already been filed. Complete Tabs 3 and 4 for all hospitals that received a section 5506 cap award(s), even if the hospital did not train displaced residents in this cost reporting period. That is, complete Tabs 3 and 4 for any hospital that receives a section 5506 cap award from any round, past or future. Be sure to enter into Tab3, cells B1, B2, B3, and B4, the provider’s name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively.
- 2) For All Hospitals that Received Section 5506 Cap Awards Under Round 1 or Round 2: Complete Tab 1 if the hospital was training displaced FTE residents in this cost reporting period, or complete Tab 1 if the hospital has displaced FTE residents in this cost reporting period and has an applicable Round 1 or Round 2 section 5506 cap adjustment in this cost reporting period. Tab 1 determines the amount of temporary cap adjustment, if any, a hospital qualifies for in a cost reporting period, and how to report the temporary cap adjustment and displaced FTE counts on the cost report. Complete Tab 2 only if the hospital was training displaced FTE residents from closed hospitals in this cost reporting period, AND a portion of the displaced FTE residents were from closed hospitals that had cap slots redistributed under Round 1 or Round 2, AND the hospital received cap awards from Round 1 or Round 2 for this cost reporting period.
- 3) For All Hospitals that Received Section 5506 Cap Awards Under Round 1 or Round 2 AND ALSO FROM Round 3 or After: Complete Tab 1 if the hospital was training displaced FTE residents in this cost reporting period, or has an applicable Round 1 or Round 2 or Round 3 (or subsequent round) section 5506 cap adjustment in this cost reporting period. Tab 1 determines the amount of temporary cap adjustment, if any, a hospital qualifies for in a cost reporting period, and how to report the temporary cap adjustment and displaced FTE counts on the cost report. Complete Tab 2 only if the hospital was training displaced FTE residents from closed hospitals in this cost reporting period, AND a portion of the displaced FTE residents were from closed hospitals that had cap slots redistributed under Round 1 or Round 2, AND the hospital received cap awards from Round 1 or Round 2 for this cost reporting period.
- 4) For All Hospitals that Received Section 5506 Cap Awards Under Round 3 or After, but NOT Under Round 1 or Round 2: Complete Tab 1 only if the hospital was training displaced FTE residents (from any hospital or program closure) in this cost reporting period. Do not complete Tab 2. (Note: There are some cells in Tab 2 that will automatically populate if Tab 1 is completed, because some cells in Tab 2 are linked to completion of Tab 1. Ignore Tab 2, but do not delete Tab 2, so that other calculations in the spreadsheet will be not be disrupted).

If completing Tab1 and/or Tab2, be sure to enter into cells B1, B2, B3, and B4, the provider’s name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. Contractors shall ask a hospital to provide any FTE information for IME and for direct GME respectively (including unweighted, weighted, and displaced FTE information) that the contractor requires in order to implement this CR.

(Note that Tab1 may also be completed for the purpose of determining if a hospital is eligible for a temporary cap adjustment under 42 CFR 413.79(h) for displaced FTEs, even in the absence of section 5506 awards).

Complete Tabs3 and 4 for all hospitals that received a section 5506 cap award(s), even if the hospital did not train displaced residents in this cost reporting period. Be sure to enter into Tab3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively.

II. IME

1. Section 5506 Cap Calculation for Hospitals that Received Slots Under Round 1 or Round 2 (and Possibly Round 3 or After)

(For hospitals that only received slots under Round 3 or a subsequent round, skip to step 1.c.)

- a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L21.
- b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22.
- c. If the hospital received slots under Round 3 or a subsequent round, determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 3 or a subsequent round (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx.

For All Hospitals that Received Section 5506 Cap Awards Under Round 3 or After, but NOT Under Round 1 or Round 2: After completing step 1.c., next, complete Tab 1, but only if the hospital was training displaced FTE residents (from any hospital or program closure) in this cost reporting period. Refer to step 3. Determination of FTE Caps and Counts, and step 4. Temporary Adjustment Calculation and EXAMPLE II below for guidance on completing Tab 1, if applicable. (Ignore references to Tab 2; do not complete Tab 2. Note: There are some cells in Tab 2 that will automatically populate if Tab 1 is completed, because some cells in Tab 2 are linked to completion of Tab 1. Ignore Tab 2, but do not delete Tab 2, so that other calculations in the spreadsheet will be not be disrupted). If completing Tab 1, to compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1 (and cell I45 if this cost reporting period has an emergency Medicare GME affiliation agreement). See the chart at the bottom of Tab 1 to obtain the temporary cap adjustments and displaced FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96

or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40). If Tab 1 is not completed, use the tables called COST REPORT ENTRIES on the bottom of Tab 4 to assist in reporting the section 5506 adjustments on the cost report. If not completing Tab 1, skip to section F below for the Direct GME cap adjustment calculation.

2. Identification of the Displaced FTE Residents (for hospitals completing Tabs 1 and 2)

- a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24).
- b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L25).
- c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell I19, and then it will automatically input into Tab 2, cell L27. Note: Tab 2, cell L27 and Tab 1, cell I19 must equal each other.)
- d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26).

3. Determination of FTE Caps and Counts (for hospitals completing Tab 1)

- a. Determine the IME adjusted FTE cap, including the applicable section 5506 cap increase(s) from *any* round. This amount is the hospital's adjusted FTE cap inclusive of all section 5506 cap awards effective through this applicable cost reporting period, reported on worksheet E, Part A, line 3.07 of Form CMS 2552-96 and on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14).
- b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17).
- c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21)
- d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs*, no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, then all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.
- e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

4. Temporary Adjustment Calculation (for hospitals completing Tabs 1 and 2)

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.) from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT the absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L31).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. - 1.b.) (NOT the absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L32).

d. Add 4.a., 4.b., and 4.c. This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59).

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1 (and cell I45 if this cost reporting period has an emergency Medicare GME affiliation agreement). See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

III. DIRECT GME

1. Section 5506 Cap Calculation for Hospitals that Received Slots Under Round 1 or Round 2 (and Possibly Round 3 or After)

(For hospitals that only received slots under Round 3 or a subsequent round, skip to step 1.c.)

- a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36.

- b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L37.

- c. If a hospital received slots under Round 3 or a subsequent round, determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 3 or a subsequent round (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 8633 Section 5506 Temp Adj Calc.xlsx.

For All Hospitals that Received Section 5506 Cap Awards Under Round 3 or After, but NOT Under Round 1 or Round 2: After completing step 1.c., next, complete Tab 1, but only if the hospital was training displaced FTE residents (from any hospital or program closure) in this cost reporting period. Refer to section 3. Determination of FTE Caps and Counts, and section 4. Temporary Adjustment Calculation, and section 5. Weighted FTE Count Calculation, and EXAMPLE II for guidance in completing Tab 1, if applicable. (Ignore references to Tab 2; do not complete Tab 2. Note: There are some cells in Tab 2 that will automatically populate if Tab 1 is completed, because some cells in Tab 2 are linked to completion of Tab 1. Ignore Tab 2, but do not delete Tab 2, so that other calculations in the spreadsheet will be not be disrupted). If completing Tab 1, see the chart at the bottom of Tab 1 to obtain the temporary cap and displaced FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40). If Tab 1 is not completed, use the tables called COST REPORT ENTRIES on the bottom of Tab 4 to assist in reporting the section 5506 adjustments on the cost report.

2. Identification of the Displaced FTE Residents (for hospitals completing Tabs 1 and 2)

- a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39).

- b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell D19, and then it will automatically input into Tab 2, cell L42. Note: Tab 2, cell L42 and Tab 1, cell D19 must equal each other.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41).

3. Determination of FTE Caps and Counts (for hospitals completing Tab 1)

a. Determine the direct GME adjusted FTE cap, including the section 5506 cap increase(s) from *any* round. This amount is the hospital's adjusted FTE cap inclusive of all section 5506 cap awards effective through this applicable cost reporting period, reported on worksheet E-3, Part IV, line 3.04 of Form CMS 2552-96 and on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs*, no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, then all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

4. Temporary Adjustment Calculation (for hospitals completing Tabs 1 and 2)

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 2 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.) from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE

residents associated with Round 1, then the Round 1 section 5506 award will “cancel” any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L46).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital’s cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will “cancel” any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. - 1.b.) (NOT absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L47).

d. Add 4.a., 4.b., and 4.c. This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54).

5. Weighted FTE Count Calculation (for hospitals completing Tab 1)

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after non-primary care rolling average:

- a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30).
- b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32).
- c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34).
- d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b.) (automatic input into Tab 1, cell D36)
- e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c.) (Tab 1, cell D38).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and non-primary care FTE counts. Complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted primary care/OB/GYN and nonprimary care FTEs, respectively, including

displaced FTEs. See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

IV. EXAMPLE I—Hospital has displaced FTEs under §413.79(h), and received section 5506 awards under Round 1, Round 2, and Round 4

Following is an example illustrating how the amount of FTEs to be reported after the rolling average should be determined and reported on the cost report:

Hospital X, provider number 00-000, has a 12/31 FYE and the Medicare contractor is working on amending the 12/31/14 cost report.

Hospital X has the following relevant FTE counts (you will need this information to complete the example):

- a. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 1 of section 5506 = 0
- b. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 2 of section 5506 = 1.00
- c. Unweighted allopathic and osteopathic displaced FTE resident count (not associated with Round 1 or Round 2, but from another hospital's closed program) = 2.00
- d. Unweighted allopathic and osteopathic displaced FTE resident count (not associated with Round 1 or Round 2, but from the closed Peninsula Hospital) = 1.00
- e. IME and direct GME total unweighted displaced FTE count = $0.00 + 1.00 + 2.00 + 1.00 = 4.00$.
- f. IME and direct GME adjusted cap, including the Rounds 1, 2, and 4 section 5506 add-ons in FYE 12/31/14 = 100.00.
- g. IME and direct GME unweighted allopathic and osteopathic FTE count *without* displaced FTE residents = 98.00.
- h. Direct GME weighted displaced FTEs in primary care and OB/GYN = 2.00.
- i. Direct GME weighted displaced FTEs in non-primary care = 1.00.
- j. Direct GME weighted primary care and OB/GYN audited FTE residents including displaced FTEs = 45.00.
- k. Direct GME weighted non-primary care audited FTE residents including displaced FTEs (excluding dental and podiatry) = 38.00.
- l. Prior year allowable IME FTEs = 100.00
- m. Prior year available beds = 300.00.

Hospital X received the following slots and effective dates under Round 1:

DGME

Effective 6/16/08:	7.00
Effective 7/1/08:	1.75
Effective date for cost reports beginning after 6/16/08:	2.60
Effective 7/1/09:	1.55
Effective 7/1/10:	17.02
Effective 7/10/10:	3.00
Effective date for cost reports beginning after 7/10/10:	1.14
Effective 7/1/11:	5.43

IME

Effective 7/1/08:	1.75
Effective date for cost reports beginning after 6/16/08:	1.07
Effective 7/1/09:	1.70
Effective 7/1/10:	21.12

Effective 7/10/10: 3.00
 Effective date for cost reports beginning after 7/10/10: 0.43
 Effective 7/1/11: 7.02

Hospital X received the following slots and effective dates under Round 2:

DGME

Effective date for cost reports beginning after 10/31/10: 1.00
 Effective 7/1/14: 1.99

IME

Effective date for cost reports beginning after 10/31/10: 1.00
 Effective 7/1/14: 1.99

Hospital X received the following slots and effective dates under Round 4:

DGME

Effective 7/1/14: 2.00

IME

Effective 7/1/14: 2.00

Enter into Tab 3, cells B1, B2, B3, and B4, the provider’s name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/14 and FYE is 12/31/14.

Enter into Tab 3, columns B through L, the effective dates and the corresponding amount of slots awarded. Round 1 effective dates and slots begin on row 22, and Round 2 effective dates and slots begin on row 63. For DGME, enter into Tab3, column B, the effective dates that say, “Effective date for cost reports beginning after mm/dd/yyyy”, and enter the corresponding slots into column C. If the effective date is just “Effective mm/dd/yyyy,” then enter into Tab3, column E the effective date, and the corresponding slots in column F. For IME, enter into Tab3, column H, the effective dates that say, “Effective date for cost reports beginning after mm/dd/yyyy,” and enter the corresponding slots into column I. If the effective date is just, “Effective mm/dd/yyyy,” then enter into Tab3, column K the effective date, and the corresponding slots into column L. For example, for IME Round 1, enter into Tab3 cell K22 “7/1/08,” and enter into cell L22 “1.75.” Then enter into cell H22 “6/16/08,” and enter into cell I22 “1.07.” Continue to enter the rest of the Round 1 and the Round 2 effective dates and slots in this manner.

Note that in columns N through R, the actual amount of each cap award that is effective during FYE 12/31/14 is automatically calculated, and prorating for slots effective 7/1/14 also occurs automatically. Also note that the total cumulative slots effective during FYE 12/31/14 are automatically calculated for DGME, Round 1, in cell O54 (should say 39.49), and Round 2, in cell O95 (should say 2.00), and for IME, Round 1, cell R55 (should say 36.09), and Round 2, in cell R96 (should say 2.00).

The detailed effective date and award information from Tab 3 must be manually transferred to Tab 4 in summary form. Tab 4 lists in chronological order the applicable round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Cells G14 and G31 on Tab4 should say “3” – the number of award rounds applicable to this cost reporting period. Follow the instructions on Tab 4.

For DGME, enter 1 into cell B19, and enter 39.49 into cell C19 (note that 39.49 comes from Tab 3, cell O54). Enter 2 into cell B20, and enter 2.00 into cell C20 (note that 2.00 comes from Tab 3, cell O95). Enter 4 into cell B21, and enter 1.01 into cell C21 (from Tab 3, cell O177).

For IME, enter 1 into cell B36, and enter 36.09 into cell C36 (note that 36.09 comes from Tab 3, cell R55). Enter 2 into cell B37, and enter 2.00 into cell C37 (note that 2.00 comes from Tab 3, cell R96). Enter 4 into cell B38, and enter 1.01 into cell C38 (from Tab 3, cell R178).

Cell H29 should say 42.50, the combined Round 1, Round 2, and Round 4 DGME cap increase, and cell H46 should say 39.10, the combined Round 1, Round 2, and Round 4 IME cap increase. At the bottom of Tab 4, there is a chart listing the lines on the cost report where the section 5506 cap awards are reported, and the amount reported on each line. Click on cell D49 to access the down arrow to toggle between cost report Form 2552-96 and Form 2552-10. Since the current cost report in this example is FYE 12/31/14, choose Form 2552-10.

Proceed to complete Tabs 1 and 2.

Enter into Tab 1, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/14 and FYE is 12/31/14.

IME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab 2, cell L21 = 36.09.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab 2, cell L22 = 2.00.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24=0.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input into Tab 2, cell L25 = 1.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (First manual input into Tab 1, cell I19 = 4.00, and then automatic input into Tab 2, cell L27 = 4.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26=3.00).

3. Determination of FTE Caps and Counts

a. Determine the IME adjusted FTE cap, including the total section 5506 cap increase(s) effective in this cost reporting period, FYE 12/31/14. This amount is reported on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14 = 100.00).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17 = 98.00).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21= 102.00)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (102.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24, should say 2.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input, should say 2.00) is the amount of displaced FTEs that are not over the cap. This means that of the 4 total displaced FTEs, 2.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap (cell I26), and *for this portion of FTEs*, no temporary cap adjustment to the rolling average is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28; should say 2.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 2.00.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (2.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (3.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30; should say 2.00).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1. However, in this FYE 12/31/14, Hospital X is not training any displaced FTE residents associated with closed hospitals from Round 1 (Tab 2, cell L24 and cell L31 are 0.00). Proceed to step 4.c.

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. However, since all of the potential for a temporary cap adjustment (Tab 1, cell I28, 2.00, step 3.e.) was already assigned under step 4.a. as a temporary cap adjustment for displaced FTE residents *not* associated with Round 1 or Round 2, there are no longer any cap slots available from which to provide a temporary cap adjustment for the 1.0 FTE associated with the closed hospital for Round 2. (Tab 2, cell L32 is 0.00). Proceed to step 4.d.

d. Add 4.a., 4.b., and 4.c. ($2.00 + 0 + 0 = 2.00$). This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29 = 2.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59 = 100.00). Note that $2.00 + 100.00 = 102.00$, the current year total unweighted allopathic and osteopathic FTEs including displaced FTEs in Tab 1, cell I21. All of the hospital's 102 FTEs are accounted for.

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1. Using the FTE information provided about Hospital X at the beginning of this example, manually input 100.00 into cell I34, 0 into cell I35, and 0 into cell I37. Cell I38 should automatically calculate 2.00 FTEs as the displaced FTEs to add to the numerator of the prior year IRB ratio, and cell I39 should automatically calculate 102.00 as the prior

year numerator. Next, manually input 300 beds into cell I40, and the revised IRB ratio of 0.340000 should automatically calculate in cell I41.

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/14, and choose Form 2552-10 as the prior year cost report because Form 2552-10 is the form to use for FYE 12/31/13.

DIRECT GME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36 = 39.49.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22 Tab2, cell L37 = 2.00.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39 = 0.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40 = 1.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (first manually input into Tab 1, cell D19 = 4.00, and then automatic input into Tab 2, cell L42 = 4.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41 = 3.00).

3. Determination of FTE Caps and Counts

a. Determine the direct GME adjusted FTE cap, including the total section 5506 cap increase(s) effective for this cost reporting period FYE 12/31/14. This amount is reported on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14 = 100.00).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17 = 98.00).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21 = 102.00)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (102.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24 =

2.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap (should say 2.00). This means that of the 4 total displaced FTEs, 2.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap (cell D26), and *for this portion of FTEs*, no temporary cap adjustment to the rolling average is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43 should say 2.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 2.00.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (2.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (3.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45, should say 2.00).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. However, in this FYE 12/31/14, Hospital X is not training any displaced FTE residents associated with closed hospitals from Round 1 (Tab 2, cell L39 and cell L46 are 0.00). Proceed to step 4.c.

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. However, since all of the potential for a temporary cap adjustment (Tab 1, cell D28, 2.00, step 3.e.) was already assigned under step 4.a. as a temporary cap adjustment for displaced FTE residents *not* associated with Round 1 or Round 2, there are no longer any cap slots available from which to provide a temporary cap adjustment for the 1.0 FTE associated with the closed hospital for Round 2. (Tab 2, cell L47 is 0.00). Proceed to step 4.d.

d. Add 4.a., 4.b., and 4.c. ($2.00 + 0.00 + 0.00 = 2.00$). This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29 should say 2.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54 should say 100.00). Note that $2.00 + 100.00 = 102.00$, the current year total unweighted allopathic and osteopathic FTEs including displaced FTEs in Tab 1, cell D21. All of the hospital's 102 FTEs are accounted for.

5. Calculation of Weighted FTE Counts

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after nonprimary care rolling average:

a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30 should say 0.50).

- b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32 = 2.00). (See information about Hospital X at the beginning of this example).
- c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34 = 1.00). (See information about Hospital X at the beginning of this example).
- d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b. = 0.50×2.00 , automatic input into Tab 1, cell D36 = 1.00)
- e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c., 0.50×1.00 , automatic input into Tab 1, cell D38 = 0.50).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and nonprimary care FTE counts. Using the information about Hospital X provided at the beginning of this example, complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted primary care/OB/GYN and nonprimary care FTEs, respectively, including displaced FTEs. (D41 = 45.00 and D44 = 38.00).

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/14, and choose Form 2552-10 as the prior year cost report because Form 2552-10 is the form to use for FYE 12/31/13.

EXAMPLE II –Hospital Z has no displaced FTEs (OR Hospital Z did not request a temporary cap adjustment under 42 CFR 413.79(h) for displaced FTEs), and Hospital Z received a section 5506 award under Round 3

Since Hospital Z, provider number 00-0001, did not receive any section 5506 awards under Round 1 or Round 2, nor is Hospital Z receiving a temporary cap adjustment for displaced FTE residents, Hospital Z must only complete Tabs 3 and 4 of CR CR 8633ection 5506 Temp Adj Calc.xlsx.

Hospital Z has a 6/30 FYE and the Medicare contractor is working on amending the 6/30/12 cost report.

Hospital Z received the following slots and effective dates under Round 3 (total DGME award = 10.00 and total IME award = 10.00):

DGME

Effective 1/5/12: 8.00
Effective 1/30/13: 2.00

IME

Effective 1/5/12: 8.00
Effective 1/30/13: 2.00

Enter into Tab 3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 7/1/11 and FYE is 6/30/12.

Enter into Tab 3, columns B through L, the effective dates and the corresponding amount of slots awarded. Scroll down to row 104; Entries for Round 3 effective dates and slots begin on row 104. Since the effective

date is just “Effective mm/dd/yyyy,” for DGME, then enter into Tab3, column E, cell E104, the effective date of 01/05/2012, and the corresponding slots in column F, cell F104, 8.00. For IME, since the effective date is just, “Effective mm/dd/yyyy,” then enter into Tab 3, column K, cell K104, the effective date of 01/05/2012, and the corresponding slots into column L, cell L104, 8.00. Continue to enter the rest of the Round 3 effective dates and slots in this manner. That is, for DGME, enter into Tab 3, column E, cell E105, the effective date of 01/30/2013, and the corresponding slots in column F, cell F105, 2.00. For IME, since the effective date is just, “Effective mm/dd/yyyy,” then enter into Tab3, column K, cell K105, the effective date of 01/30/2013, and the corresponding slots into column L, cell L105, 2.00.

Note that in columns N through R, the actual amount of each cap award that is effective during FYE 6/30/12 is automatically calculated, and prorating for the 8.00 slots effective 1/5/12 also occurs automatically (cells O104 and R104). Also note that the total cumulative slots effective during FYE 6/30/12 are automatically calculated for DGME, Round 3, in cell O136 (should say 3.89), and for IME, Round 3, cell R137 (should say 3.89).

The detailed effective date and award information from Tab 3 must be manually transferred to Tab 4 in summary form. Tab 4 lists in chronological order the applicable round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Cells G14 and G31 on Tab 4 should say “1” – the number of award rounds applicable to this cost reporting period. Follow the instructions on Tab 4.

For DGME, enter 3 into cell B19, and enter 3.89 into cell C19 (note that 3.89 comes from Tab 3, cell O136).

For IME, enter 3 into cell B36, and enter 3.89 into cell C36 (note that 3.89 comes from Tab 3, cell R137).

Cell H29 should say 3.89, the Round 3 DGME cap increase effective for FYE 6/30/12, and cell H46 should say 3.89, the Round 3 IME cap increase effective for FYE 6/30/12. At the bottom of Tab 4, there is a chart listing the lines on the cost report where the section 5506 cap awards are reported, and the amount reported on each line. Click on cell D49 to access the down arrow to toggle between cost report Form 2552-96 and Form 2552-10. Since the current cost report in this example is FYE 6/30/12, choose Form 2552-10.

V. Cost Report Process - Steps to Report the IME and Direct GME Section 5506 FTE Resident Cap Increase

1. Determine if the cost report was filed on CMS Form 2552-96 or CMS Form 2552-10. If it was filed on CMS Form 2552-10, then skip to step 4.
2. If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 3.a.

If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 3.a. and incorporate the applicable steps in this CR into the desk review.

If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 3.a. and complete the applicable steps in this CR before settling the cost report.

3. For Form 2552-96 Cost Reports:
 - a. Report the amount of the section 5506 cap increase for IME and/or direct GME respectively that *is effective during the cost report that you are amending* on worksheet S-3, Part I, line 17. Use column 7 for the IME cap increase and column 8 for the direct GME cap increase. (Normally line 17 is for

“Other Long Term Care Facilities,” but we are adopting this line and its columns for special reporting of the section 5506 cap increases on the Form 2552-96 cost reports, and it will serve as an indicator as to whether the hospital received a section 5506 cap increase in this cost reporting period). If you complete Tab3 and Tab4 of the CR 8633 Section 5506 Temp Adj Calc.xlsx, then the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amounts to be entered on worksheet S-3, Part I, line 17. Proceed to step 3.b.

- b. **IME:** On worksheet E, Part A, line 3.06, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.06 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital’s allowable FTE count and IME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.06, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tab3 and Tab4 of the CR 8633 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E, Part A, line 3.06. (Note that this calculated amount for line 3.06 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital’s IME payment on that cost report. For hospitals that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards under Round 1 or Round 2, complete Tab1 and Tab2 of the CR 8633 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E, Part A. Refer to section II. below for detailed instructions on completing CR 8633 Section 5506 Temp Adj Calc.xlsx and worksheet E, Part A.

- c. **Direct GME:** On worksheet E-3, Part IV, line 3.03, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.03 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital’s allowable FTE count and direct GME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.03, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.) Complete Tab3 and Tab4 of the CR 8633 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E-3, Part IV, line 3.03. (Note that this calculated amount for line 3.03 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital’s direct GME payment on that cost report. For hospitals that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards under Round 1 or Round 2, complete Tab1 and Tab2 of CR 8633 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E-3, Part IV. Refer to section II. below for detailed instructions on completing CR 8633 Section 5506 Temp Adj Calc.xlsx and worksheet E-3, Part IV on the CMS Form 2552-96 and the worksheet E-4 on the CMS Form 2552-10.

4. If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 4.a.

If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 4.a. and incorporate the applicable steps in this CR into the desk review.

If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 4.a. and complete the applicable steps in this CR before settling the cost report.

For Form 2552-10 Cost Reports:

- a. IME: Report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E, Part A, making revisions as necessary.

The instructions for IME on worksheet E, Part A, line 8.02 state, “Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. *Further subscript this line (lines 8.03 through 8.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase . . .*” The phrase “if the hospital receives FTE cap slot awards on more than one occasion under section 5506” means that a hospital could receive slots from more than one round of section 5506 applications; that is, from Round 1 or Round 2 or Round 3 and/or from future teaching hospital closures. Upon the completion of each round of section 5506 application processes, CMS posts the awards on its website and issues an award letter to each hospital receiving section 5506 slots under that round. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the website and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective over multiple cost reporting periods, line 8.02 will reflect the *total* IME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 8.03 will reflect the *total* IME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2 and Round 3, then line 8.02 would reflect the awards from Round 2, and line 8.03 would reflect the awards from Round 3, and so forth. Each subscript of line 8.02 will eventually reflect the total IME section 5506 cap increase received for each respective round).

- b. Direct GME: Report the amount of the section 5506 cap increase for direct GME on worksheet E-4, line 4.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E-4, making revisions as necessary.

The instructions for direct GME on worksheet E-4, line 4.02 state, “Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. *Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase . . .*” The phrase “if the hospital receives FTE cap slot awards on more than one occasion under section 5506” means that a hospital could receive slots from more than one round of section 5506 applications; that is, from Round 1 or Round 2 or Round 3 and/or from future teaching hospital closures. Upon the

completion of each round of section 5506 application processes, CMS posts the awards on its website and issues an award letter to each hospital receiving section 5506 slots under that round. The number of times line 4.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the website and the number of award letters the hospital receives for each respective round. Line 4.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective, line 4.02 will reflect the *total* direct GME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 4.03 will reflect the *total* direct GME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2 and Round 3, then line 4.02 would reflect the awards from Round 2, and line 4.03 would reflect the awards from Round 3, and so forth. Each subscript of line 4.02 will eventually reflect the total direct GME section 5506 cap increase received for each respective round).

R1371_OTN1.xlsx
Tab1 Displaced Resident Review

Provider Name
Provider No.
FYB
FYE

Displaced Resident Cost Report Calculation

PURPOSE: To report IME and DGME displaced resident FTEs due to the closure of another teaching hospital and/or program on the Medicare cost report Complete Tab1 if the provider has displaced residents but no section 5506 cap awards, OR complete Tab1 if the provider has displaced residents and section 5506 award(s)

= Input cell

DGME

DGME adjusted cap, including ACA 5506 add-on (E-4 line 5)

CY unwt'd A&O FTEs w/o displaced residents

CY unwt'd A&O displaced resident FTEs

CY total unwt'd A&O FTEs (including displaced residents) 0.00

FTEs over the CAP 0.00

Portion of unwt'd displaced FTEs not over the cap (if negative or zero, all displaced FTEs are in excess of cap) 0.00

Potential unwt'd temp. cap adjustment for displaced residents 0.00

Unwt'd temp cap adj for displaced residents 0.00

Ratio of unwt'd temp cap adj to total displaced FTEs 0.00

CY weighted displaced FTEs Prim. Care&OBGYN

CY weighted displaced FTEs Non Primary Care

Final temp. cap adj. wght'd displ. FTEs Prim. Care&OBGYN 0.00

Final temp. cap adj. wght'd displ. FTEs Non-Primary Care 0.00

CY wght'd primary care and OBGYN FTEs (including displaced residents)

CY wght'd NonPrim.Care FTEs (excl. dent. & podiatry) (including displaced residents)

IME

IME adjusted cap, including ACA 5506 add-on (E Part A line 9)

CY unwt'd A&O FTEs w/o displaced residents

CY unwt'd A&O displaced resident FTEs

CY total unwt'd A&O FTEs (including displaced residents) 0.00

FTEs over the CAP 0.00

Portion of unwt'd displaced FTEs not over the cap (if negative or zero, all displaced FTEs are in excess of cap) 0.00

Potential Temp. cap adjustment for displaced residents 0.00

Total temp. cap adjustment for displaced residents 0.00

Prior Year Resident-to-Bed Ratio:

Prior Year allowable IME FTEs (PY E part A line 12)

Add on for increase in affiliation FTEs

Add on for new programs in initial yrs

Add on for CY displaced residents 0.00

Prior Year numerator 0.00

Prior Year available beds (PY E Part A line 4)

Revised IRB Ratio 0.000000

formula = (PY FTE+affiliation increase+new programs in initials years + CY add on for displaced residents)/PY Beds

Override of PY IRB ratio for a cost report w/ Emergency Medicare Affiliation Agreement (should = calculated CY IRB ratio on cost report after updating all other IME data listed below), if N/A leave blank

CY Cost Reporting Form: 2552-10 (2552-96 or 2552-10) Click on cell C47 to access the down arrow to toggle between 2552-96 and 2552-10.

Prior Year Cost Reporting Form 2552-10 (2552-96 or 2552-10) Click on cell C49 to access the down arrow to toggle between 2552-96 and 2552-10.

COST REPORT ENTRIES:

W/S	Line	Column	Adjustment
E-4		6	1 0.00
E-4		8	1 0.00
E-4		16	1 0.00
E-4		8	2 0.00
E-4		16	2 0.00
E, part A		10	1 0.00
E, part A		17	1 0.00
E, part A		20	1 0.000000

Regulation 42 CFR Sec. 412.105(f)(1)(v), 413.79(h) & (i) & (m)
Reference CMS Pub 15-2 Sec. 4030.1, 4034

R1371_OTN1.xlsx
 Tab2 Round1&2 ACA 5506 Offset

Provider Name
 Provider No.
 FYB
 FYE

Displaced Resident Cost Report Calculation

PURPOSE: To calculate the net temporary cap adjustment for displaced residents when there is also a round 1 or round 2 ACA 5506 cap award

Complete this worksheet only IF:

- The provider was training displaced residents from closed hospitals in this cost reporting period
- AND
- A portion of the displaced residents were from closed hospitals that had caps slots redistributed under round 1 or round 2 of ACA 5506
- AND
- The provider received cap awards from round 1 or 2 of ACA 5506 for this cost reporting period
- OTHERWISE
- Leave this schedule blank

1) IME Calculation	
a. Section 5506 cap awards applicable to this cost report from round 1	0.00
b. Section 5506 cap awards applicable to this cost report from round 2	0.00
c. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506	0.00
d. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506	0.00
e. Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)	0.00
f. Total displaced FTE resident count	0.00
g. Portion of displaced FTE residents potentially eligible for temporary cap adjustment	0.00
h. Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards	0.00
i. Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)	0.00
j. Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)	0.00
k. Total allowable temporary cap adjustment for displaced residents	0.00
2) DGME Calculation	
a. Section 5506 cap awards applicable to this cost report from round 1	0.00
b. Section 5506 cap awards applicable to this cost report from round 2	0.00
c. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506	0.00
d. unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506	0.00
e. Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)	0.00
f. Total displaced FTE resident count	0.00
g. Portion of displaced FTE residents potentially eligible for temporary cap adjustment	0.00
h. Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards	0.00
i. Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)	0.00
j. Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)	0.00
k. Unwtd temp cap adj for displaced residents	0.00
l. Determine what portion of step k. should be added to the primary care rolling avg and/or to the non-primary care rolling avg	0.00
m. Weighted portion to be added to the primary care/OB/GYN rolling avg on 2552-96 E-3 Pt IV line 3.22 or 2552-10 E-4 line 16	0.00
n. Weighted portion to be added to the non-primary care rolling avg on 2552-96 E-3 Pt IV line 3.16 or 2552-10 E-4 line 16	0.00
o. Total adjustment to DGME rolling average	0.00

R1371_OTN1.xlsx
Tab3 ACA 5506 Cap Award Detail

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 1															
DGME				IME				DGME				IME			
Effective date for Cost Reports Beginning After:				Effective date for Cost Reports Beginning After:				Effective date for Cost Reports Beginning After:				Effective date for Cost Reports Beginning After:			
Slots	Per CR	Begin Date	End Date	Slots	Per CR	Begin Date	End Date	Slots	Per CR	Begin Date	End Date	Slots	Per CR	Begin Date	End Date
Total DGME slots per this round (sum of Col. C + F)				Total IME slots per this round (sum of Col. N + O)				Total DGME slots per this round applicable to this cost reporting period (sum of Col. Q + R)				Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)			
0.00				0.00				0.00				N/A			

R1371_OTN1.xlsx
 Tab3 ACA 5506 Cap Award Detail

Provider Name
 Provider No.
 FYB
 FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 2															
DGME					IME					Detail of Award Applicable to this Cost Reporting Period					
Effective date for Cost Reports Beginning After:		Slots Effective:	Slots	Per CR	Effective date for Cost Reports Beginning After:		Slots Effective:	Slots	Per CR	DGME		IME		Per Effective Date	
Slots	Begin Date	Per Effective Date	Begin Date		Slots	Begin Date	Per Effective Date	Begin Date		Slots	Begin Date	Per Effective Date			
Total DGME slots per this round (sum of Col. C + F)										0.00					
Total IME slots per this round (sum of Col. I + L)										0.00					
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)										N/A					
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)										N/A					

R1371_OTN1.xlsx
Tab3 ACA 5506 Cap Award Detail

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE:

To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 4													
	DGME				IME				Detail of Award Applicable to this Cost Reporting Period				
Effective date for Cost Reports Beginning After:	Slots Effective:	Slots			Effective date for Cost Reports Beginning After:	Slots Effective:	Slots			Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)				0.00									
Total IME slots per this round (sum of Col. I + L)													
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)													
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)				0.00									

R1371_OTN1.xlsx
 Tab3 ACA 5506 Cap Award Detail

Provider Name
 Provider No.
 FYB
 FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents.

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 5								
	DGME		IME		Detail of Award Applicable to this Cost Reporting Period			
	Effective date for Cost Reports Beginning After: Slots	Slots Effective: Slots	Effective date for Cost Reports Beginning After: Slots	Slots Effective: Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)		0.00						
Total IME slots per this round (sum of Col. I + L)				0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)				N/A				
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)				N/A				

R1371_OTN1.xlsx
 Tab3 ACA 5506 Cap Award Detail

Provider Name
 Provider No.
 FYB
 FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 8												
DGME			IME			Detail of Award Applicable to this Cost Reporting Period			IME			
Effective date for Cost Reports Beginning After:	Slots	Effective: Slots	Effective date for Cost Reports Beginning After:	Slots	Effective: Slots	Slots Per CR	Begin Date	Per Effective Date	Slots Per CR	Begin Date	Per Effective Date	
Total DGME slots per this round (sum of Col. C + F)										0.00		
Total IME slots per this round (sum of Col. I + L)									N/A			
Total IME slots per this round applicable to this cost reporting period (sum of Col. N + O)												N/A
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)												N/A

R1371_OTN1.xlsx
 Tab3 ACA 5506 Cap Award Detail

Provider Name
 Provider No.
 FYB
 FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 9													
DGME				IME				Detail of Award Applicable to this Cost Reporting Period					
Effective date for Cost Reports Beginning After:	Slots	Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Effective:	Slots	Slots Begin Date	Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date	IME	IME
Total DGME slots per this round (sum of Col. C + F)											0.00		
Total IME slots per this round (sum of Col. I + L)													
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)													
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)													
												N/A	N/A

RTPM_OTM1.xlsx
Table ACR 6038 Cap Award Detail

Provider Name
 Provider No
 PTB
 PVL

ACA 6038 PBE and DORS PTE Cap Awards

PURPOSE: To list the PBE and DORS PTE cap awards and effective dates to transfer to "Table ACR 6038 Cap Award Summary" worksheet. Tables 3 and 4 are completed by all providers that received section 6038 cap awards, even if the providers did not have deployed residents.

Note: Unlike cap awards for each year awarded for CMI, the award to receive the cap awards in the award report. If the awarded did not receive cap increases in a particular year or that year's limit was not met, leave that section blank.

= Input cell

Effective date for CMI Reports Worksheet /PTE/ /PBE	CMI		Award P1		Award P2		Award P3		
	Ratio	Effective Dates	Ratio	Effective Dates	Ratio	Effective Dates	Ratio	Effective Dates	
	Per Cap Award Date	Per Resident Award Date	Per Cap Award Date	Per Resident Award Date	Per Cap Award Date	Per Resident Award Date	Per Cap Award Date	Per Resident Award Date	
Total CMI/PTB table per this award form of Col. C + P1								6.04	
Total PTE table per this award form of Col. I + U									
Total CMI/PTB table per this award applicable to the award reporting period form of Col. N + Q1									
Total PTE table per this award applicable to the award reporting period form of Col. V + W									

RI9PL_DTDW1.xlsx
 Table ACA 2009 Cap Award Detail

Provider Name
Provider No.
PTB
PVI

ACA 2009 MSE and DOWNS PTH Cap Awards

PURPOSE: To list the MSE and DOWNS PTH cap awards and effective dates to transfer to "Table ACA 2009 Cap Award Summary" worksheet.
 Table 3 and 4 are completed by all providers that received section 2009 cap awards, even if the providers did not train displaced residents.

Note: Unlike cap awards for each year awarded for CASL, the awards for each year are awarded in the award year. If the awarded did not receive cap increases in a particular year or that year's award was not measured, leave that section blank.

Legend

Effective date for CASL Reports Available 1/1/09 - 3/31/09	MSE Effective Date	MSE Effective Date	MSE Effective Date	MSE Effective Date	Total of Award Transfers to All Cap Awards				
					Per Cap Award Date	Per Cap Award Date	Per Cap Award Date	Per Cap Award Date	
					0.00	0.00	0.00	0.00	0.00
Total DOWNS awards per site award term of Col. C + F)									
Total MSE awards per site award term of Col. I + J)									
Total Cap Awards per site award applicable to the award reporting period from Col. N + O)									
Total MSE awards per site award applicable to the award reporting period from Col. G + H)									

RI_SF1_DTMH_L046
 Table ACA 2008 Cap Award Detail

Provider Name
 Provider No
 FTS
 FTE

ACA 2008 HSE and DORS FTE Cap Awards

PURPOSE: To list the HSE and DORS FTE cap awards and effective dates to transfer to "Table ACA 2008 Cap Award Summary" worksheet.
 Tables 3 and 4 are completed by all providers that received section 2008 cap awards, even if the providers did not have displaced residents.

Note: List the cap awards by each year awarded for each. We want to capture the cap awards in the correct year. If the awarded did not receive cap increases in a particular year or that year's limit was not met, leave that section blank.

= Input cell

Effective date	2008		2009		2010		2011		2012		2013		Award
	Resident	Per Cap	Resident	Per Cap	Resident	Per Cap	Resident	Per Cap	Resident	Per Cap	Resident	Per Cap	
Total 2008 awards per site award form of Col. C + F)													N/A
Total 2009 awards per site award form of Col. I + J)													
Total 2010 awards per site award form of Col. M + O)													

RI_SF1_D11M1.xlsx
Table: ACA 2014 Cap Award Detail

Provider Name
Provider No
FTB
FTL

ACA 2014 HSE and DORS PTE Cap Awards

PURPOSE: To list the HSE and DORS PTE cap awards and effective dates to transfer to "Table ACA 2014 Cap Award Summary" worksheet.
Table 3 and 4 are completed by all providers that received section 2002 cap awards, even if the providers did not truly displaced recipients

Note: Unlike cap awards for each year provided for CSM, we want to capture the cap awards in the correct year. If the provider did not receive cap increases in a particular year or that year's limit not met/covered, leave that section blank.

= Input cell

			Award YY			
Effective date for Cost Reports Contract Year	2014		2015		2016	
	Recs Effective	Costs	Recs Effective	Costs	Recs Effective	Costs
Total CSMHLE costs per site normal (sum of Col. C + F)			Total DORSHLE costs per site normal (sum of Col. I + J)			
Total HSE costs per site normal (sum of Col. K + O)			Total PTE costs per site normal (sum of Col. N + Q)			
Total HSE costs per site normal attributable to the cost recipient (total sum of Col. G + R)			Total PTE costs per site normal attributable to the cost recipient (total sum of Col. H + S)			

			Award YY			
Effective date for Cost Reports Contract Year	2014		2015		2016	
	Recs Effective	Costs	Recs Effective	Costs	Recs Effective	Costs
Total CSMHLE costs per site normal (sum of Col. C + F)			Total DORSHLE costs per site normal (sum of Col. I + J)			
Total HSE costs per site normal (sum of Col. K + O)			Total PTE costs per site normal (sum of Col. N + Q)			
Total HSE costs per site normal attributable to the cost recipient (total sum of Col. G + R)			Total PTE costs per site normal attributable to the cost recipient (total sum of Col. H + S)			

MI9PL011M1.L006
Table ACR 0808 Cap Award Detail

Provider Name
Provider No.
FTB
FTL

ACA 834F RFE and DORS PTE Cap Awards

PURPOSE: To list the RFE and DORS PTE cap awards and effective dates to transfer to "Table ACR 0808 Cap Award Summary" worksheet.
Table 3 and 4 was completed by all providers that received section 0808 cap awards, even if the providers did not have displaced residents.

Note: Unlike cap awards by state provided by CAEM, we were to exclude the cap awards in the award count. If the provider did not receive cap increases in a particular report or that report has not yet occurred, leave that section blank.

= Input cell

		Award 10				Award 11				Award 12			
Effective date	CAEM	RFE	DORS	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap
CAEM	RFE	DORS	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap	Per Cap
Total CAEM state per the report from of Col. C + F)		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total RFE state per the report from of Col. I + J		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total DORS state per the report from of Col. M + Q		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total CAEM state per the report from of Col. G + P)		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total RFE state per the report from of Col. I + J		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total DORS state per the report from of Col. M + Q		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total CAEM state per the report from of Col. G + P)		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total RFE state per the report from of Col. I + J		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	
Total DORS state per the report from of Col. M + Q		RFE		DORS		Per Cap		Per Cap		Per Cap		Per Cap	

RT371_DTN1.xlsx
Tab4 ACA 5506 Cap Award Summary

Provider Name
Provider No.
FTE
FTE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To report IME and DGME FTE cap awards per ACA Section 5506 on the Medicare cost report. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents.
- Input cell

DGME

- 1) Number of award rounds applicable to this cost reporting period:
- 2) Enter in chronological order the Applicable Round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Obtain the amounts from Tab3 ACA 5506 Cap Award Detail, col. D. For example, if the hospital received slots under Round 1, enter 1 into cell B19. Obtain the Round 1 Increase Per Round to enter into cell C19 from Tab 3, cell D54. If the hospital did not receive slots under Round 1 but did receive slots under Round 2, enter 2 into cell B19. Obtain the Round 2 Increase Per Round to enter into cell C19 from Tab 3, cell D95. If the hospital received slots under Round 1 and Round 2, enter 1 into cell B19, and obtain the Round 1 Increase Per Round to enter into cell C19 from Tab 3, cell D54; enter 2 into cell B20, and obtain the Round 2 Increase Per Round to enter into cell C20 from Tab 3, cell D95. If the hospital did not receive slots under Round 1 or Round 2, but did receive slots under Round 3, enter 3 in cell B19. Obtain the Round 3 Increase Per Round to enter into cell C19 from Tab 3, cell D136. If the hospital received slots under Round 1 and Round 2 and Round 4, enter 4 into cell B21. Obtain the Round 4 Increase Per Round to enter into cell C21 from Tab 3, cell D177. If the hospital did not receive slots in a particular Round, do not enter any information for that Round.

Applicable Round #	Increase Per Round

Applicable Round #	Increase Per Round

Total 0.00

IME

- 3) Number of award rounds applicable to this cost reporting period:
- 4) Enter in chronological order the Applicable Round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Obtain the amounts from Tab3 ACA 5506 Cap Award Detail, col. R. For example, if the hospital received slots under Round 1, enter 1 into cell B36. Obtain the Round 1 Increase Per Round to enter into cell C36 from Tab 3, cell R55. If the hospital did not receive slots under Round 1 but did receive slots under Round 2, enter 2 into cell B36. Obtain the Round 2 Increase Per Round to enter into cell C36 from Tab 3, cell R96. If the hospital received slots under Round 1 and Round 2, enter 1 into cell B36, and obtain the Round 1 Increase Per Round to enter into cell C36 from Tab 3, cell R55; enter 2 into cell B37, and obtain the Round 2 Increase Per Round to enter into cell C37 from Tab 3, cell R96. If the hospital did not receive slots under Round 1 or Round 2, but did receive slots under Round 3, enter 3 in cell B36. Obtain the Round 3 Increase Per Round to enter into cell C36 from Tab 3, cell R137. If the hospital received slots under Round 1 and Round 2 and Round 4, enter 4 into cell B38. Obtain the Round 4 Increase Per Round to enter into cell C38 from Tab 3, cell R178. If the hospital did not receive slots in a particular Round, do not enter any information for that Round.

Applicable Round #	Increase Per Round

Applicable Round #	Increase Per Round

R1371_DTN1.xlsx
Tab4 ACA 5506 Cap Award Summary

Provider Name
Provider No.
FTE
FTE

ACA 5506 BME and DSME FTE Cap Awards

Total 0.00

R1371_DTM1.xlsx
Tab4 ACA 5506 Cap Award Summary

Provider Name
Provider No.
FTE
FTE

ACA 5506 IME and OSME FTE Cap Awards

CY Cost Reporting Form: 2552-10
2552-98 or 2552-99 Click on cell D49 to access the down arrow to toggle between 2552-96 and 2552-10.

COST REPORT ENTRIES:

W/S	Line	Column	Adjustment
B-4	4.02	1	0.00
B-4	4.03	1	0.00
B-4	4.04	1	0.00
B-4	4.05	1	0.00
B-4	4.06	1	0.00
B-4	4.07	1	0.00
B-4	4.08	1	0.00
B-4	4.09	1	0.00
B-4	4.10	1	0.00
B-4	4.11	1	0.00
B-4	4.12	1	0.00
B-4	4.13	1	0.00
B-4	4.14	1	0.00
B-4	4.15	1	0.00
B-4	4.16	1	0.00
B-4	4.17	1	0.00
B-4	4.18	1	0.00
B-4	4.19	1	0.00
B-4	4.20	1	0.00
B, Part A	0.02	1	0.00
B, Part A	0.03	1	0.00
B, Part A	0.04	1	0.00
B, Part A	0.05	1	0.00
B, Part A	0.06	1	0.00
B, Part A	0.07	1	0.00
B, Part A	0.08	1	0.00
B, Part A	0.09	1	0.00
B, Part A	0.10	1	0.00
B, Part A	0.11	1	0.00
B, Part A	0.12	1	0.00
B, Part A	0.13	1	0.00
B, Part A	0.14	1	0.00
B, Part A	0.15	1	0.00
B, Part A	0.16	1	0.00
B, Part A	0.17	1	0.00
B, Part A	0.18	1	0.00
B, Part A	0.19	1	0.00
B, Part A	0.20	1	0.00

Regulation 42 CFR Sec. 412.100(f)(1)(v), 413.79(d) & (f) & (n)

References CMS Pub 15-2 Sec. 4830.1, 4834