Technical Supplement: Specifications for Standardizing Medicare Claims for IOM Request
February 2011

The tables below contain technical specifications for computing standardized Medicare payment amounts for 2008. The first column of each table describes the settings and setting subdivisions for which the standardization algorithms apply, the second column describes the selection criteria used to identify claims for the specified setting, the third column displays the formula(s) used in the standardization algorithm, and the fourth column contains references and comments about the algorithm. Data elements that actually come from the Medicare claims data are shown in red. Rows in blue immediately preceding the detailed technical specifications describe the specifications in non-programming terminology.

General Category:

Setting	Selection Criteria	2008 Standardized Payment Computations	References/Comments
Acute Hospital	**Acute care inpatient claims**		
	NCH_CLM_TYPE_CD = 60, 61 and Substr(PROVIDER_ID,3,1) = 0		The NCH_CLM_TYPE_CD and PROVIDER_ID values are from the ResDAC website.
Transfer Claims	Claims where the length of stay is less than the geometric mean length of stay for that DRG and either the patient was transferred to another acute facility or was discharged to PAC and the DRG is a PAC DRG.	The standardized payment is estimated as the Medicare payment amount on the claim divided by the percent attributed to labor and capital times the wage index plus the percent attributed to non-labor.	
	LOS + 1 < GMLOS and Substr(PROVIDER_ID,1,2) not = 21 Where LOS=max(clm_thru_dt–clm_from_dt,1) and either (PTNT_DSCHRG_STUS_CD in (02,04,05,09,43,66,30) or (PTNT_DSCHRG_STUS_CD in (03,06,08,50,51,61,62,63,64,65,71,72) and post_acute_care_drg='Yes')	STD_PMT_AMT = MEDICARE_PMT_AMT / (.72*Wage_Index + .28) Where Wage_Index is based on the provider CBSA and MEDICARE_PMT_AMT = CLM_PMT_AMT	The gmlos and post_acute_care_drg fields are in the DRG_WGT crosswalk. PTNT_DSCHRG_STUS_CD values are from the ResDAC website. 2008 Acute Inpatient Downloadable Files – DRGs (first 9 months of 2008) http://www.cms.gov/AcuteInpatientPPS/FFD/list.asp?filtertype=dual&datefiltertype=-1&datefilterinterval=&filtertype=data&datafiltertype=3&datafiltervalue=FY08+Final+Notice+Data&keyword=&intNumPerPage=10&cmdFilterList=Show+Items&listpage=1 table 5 DRGs (last 3 months of 2008) http://www.cms.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1230673&intNumPerPage=10 table 5

Acute Hospital (cont.)			Impact file 2008 – use Post Reclass Wage Index. Some wage indexes were updated with Section 508 reclassification (an email attachment from Nisha Bhat p.9808). This file has provider_id, cbsa and wage index. http://www.cms.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=dual,%20data&filterValue=FY08%20Final%20Notice%20Data&filterByDID=3&sortByDID=2&sortOrder=ascending&itemID=CMS1198516&intNumPerPage=10
Maryland Claims	Claims for acute care facilities in Maryland.	Same computation as for transfer claims.	
	Substr(PROVIDER_ID,1,2) = 21	STD_PMT_AMT = MEDICARE_PMT_AMT / (.72*Wage_Index + .28) Where Wage_Index is based on the provider CBSA and MEDICARE_PMT_AMT = CLM_PMT_AMT	
Interim Claims	Claims for patient that is not discharged.	No standardized payment.	
	PTNT_DSCHRG_STUS_CD = 30 or DSCHRG_DT is Null	STD_PMT_AMT = Null	
Others Claims	All other acute care claims with a discharge.	The standardized payment is estimated as the sum of the base payment amounts for labor, non-labor and capital times the DRG weight plus the high-cost outlier payment amount.	
	Not Transfer or Maryland claim and (PTNT_DSCHRG_STUS_CD not = 30 and DSCHRG_DT not Null)	STD_PMT_AMT = (3478.45 + 1512.12 + 426.14)*DRG_WGT + HC_OUTLIER_AMT Where DRG_WGT is the weight corresponding to the CLM_DRG_CD and HC_OUTLIER_AMT = NCH_DRG_OUTLIER_APRV_PMT_AMT / (.72*Wage_Index + .28)	Base rates for acute -CMS-1533-F2: http://www.cms.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?filterType=dual,%20data&filterValue=2008&filterByDID=4&sortByDID=4&sortOrder=ascending&itemID=CMS1228401&intNumPerPage=10 table 1A, 1D The outlier labor portion (.72) is computed as the sum of the labor and capital base divided by the sum of the three base amounts. ((3478.45 +426.14)/(3478.45 + 1512.12 + 426.14))

Setting	Selection Criteria	2008 Standardized Payment Computations	References/Comments
Acute Hospital (cont.)	**Acute care inpatient claims**		
Subdivisions of Acute Claims	Distinguish between payments for ER days, ICU days, IMC days and standard days.	The standardized payment computed above is proportionally divided among the setting subdivisions based on the proportion of days spent in the subdivision.	
	If REV_CNTR in ('0450','0451','0452','0456','0459') then ER Else if REV_CNTR in ('0200','0201','0202','0203','0204','0207','0208','0209') then ICU Else if REV_CNTR in ('0206') then IMC Else regular acute care	The proportion of days in the ICU and IMC setting subdivisions = REV_CNTR_UNIT_CNT / (CLM_UTLZTN_DAY_CNT+ CLM_NON_UTLZTN_DAY_CNT)	The REV_CNTR values are from the ResDAC website. Note there is no payment associated with the ER setting subdivision and for other bed types the REV_CNTR_UNIT_CNT = (CLM_UTLZTN_DAY_CNT+ CLM_NON_UTLZTN_DAY_CNT) on claims examined.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Long-Term Care (LTC)	**LTC inpatient claims**		
	NCH_CLM_TYPE_CD = 60, 61 and Substr(PROVIDER_ID,3,2) = 20 - 22		The NCH_CLM_TYPE_CD and PROVIDER_ID values are from the ResDAC website.
Short Stay Outliers	Claims where the length of stay is less than the 5/6th of geometric mean length of stay for that DRG	The standardized payment is estimated as the Medicare payment amount on the claim divided by the percent attributed to labor and capital times the wage index plus the percent attributed to non-labor.	
	LOS < GMLOS*5/6 Where LOS= CLM_UTLZTN_DAY_CNT	STD_PMT_AMT = MEDICARE_PMT_AMT / (.76*Wage_Index + .24) Where Wage_Index is based on the provider CBSA and MEDICARE_PMT_AMT = CLM_PMT_AMT	
Others Claims	All other long term care claims.	The standardized payment is computed as the base payment amount times the LTC_DRG weight plus the high-cost outlier payment amount.	
		STD_PMT_AMT = (38356.45)*LTC_DRG_WGT + HC_OUTLIER_AMT Where LTC_DRG_WGT is the weight corresponding to the CLM_DRG_CD and HC_OUTLIER_AMT = NCH_DRG_OUTLIER_APRV_PMT_AMT / (.76*Wage_Index + .24)	UnAdj Base Rate 2008 – RY 2008 CMS-1529-F look for 'the standard Federal rate for RY 2008' http://www.gpo.gov/fdsys/pkg/FR-2007-05-11/pdf/07-2206.pdf LTC-DRG Weights for fiscal years can be found – this site has several files. You need 2 of these: one for 1/1-9/30 and the other for 10/1-12/31. http://www.cms.gov/LongTermCareHospitalPPS/06_ltcdrg.asp#TopOfPage The outlier labor portion (.76) was confirmed by CMS.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Inpatient Rehabilitation Facility (IRF)	**IRF claims**		
	NCH_CLM_TYPE_CD = 60, 61 and Substr(PROVIDER_ID,3,4) = 3025 - 3099 or Substr(PROVIDER_ID,3,1) in ('R','T')		The NCH_CLM_TYPE_CD and PROVIDER_ID values are from the ResDAC website.
All Claims	All IRF claims.	The standardized payment is computed as the base payment amount times the CMG weight plus the high-cost outlier payment amount.	
		STD_PMT_AMT = (13,451)*CMG_WGT + HC_OUTLIER_AMT Where CMG_WGT is the weight for the HCPCS_CD corresponding to the REV_CNTR =0024 and HC_OUTLIER_AMT = NCH_DRG_OUTLIER_APRV_PMT_AMT / (.76*Wage_Index + .24)	Unadjusted Base Rate (2008) – CMS-1551-F, table 3 http://www.cms.gov/InpatientRehabFacPPS/LIRFF/list.asp?intNumPerPage=30 CMG Weights for 2008 http://www.cms.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage When Rev_cntr = 0024, hcpcs_cds start with A, B, C or D and this determines the tier. The last four digits of the hcpcs_cd gives the CMG number. B-tier 1, C-tier 2, D-tier-3, A-none http://www.cms.hhs.gov/Transmittals/Downloads/R276CP.pdf The outlier labor portion (.76) was confirmed by CMS.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Inpatient Psychiatric Facility (IPF)	**IPF claims**		
	NCH_CLM_TYPE_CD = 60, 61 and Substr(PROVIDER_ID,3,2) = 40 - 44 or Substr(PROVIDER_ID,3,1) in ('M','S')		The NCH_CLM_TYPE_CD and PROVIDER_ID values are from the ResDAC website.
All Claims	All IPF claims.	The standardized payment is computed as the base payment amount times the IPF weight times the age factor times the comorbid factor times the los factor plus the high-cost outlier payment amount plus electric shock therapy base amount times electric shock therapy units.	
		STD_PMT_AMT = (614.99)*IPF_WGT*age_factor*comorbid*los_factor + HC_OUTLIER_AMT + 264.77* ECT units Where IPF_WGT is the weight corresponding to the CLM_DRG_CD and age at clm_thru_dt and comorbid is determined by secondary dgns group and LOS= CLM_UTLZTN_DAY_CNT and HC_OUTLIER_AMT = NCH_DRG_OUTLIER_APRV_PMT_AMT / (.76*Wage_Index + .24)	Per Diem Rate and ECT Rate (2008) – Federal per diem base rate, ECT rate yields an ECT rate of http://www.cms.gov/quarterlyproviderupdates/downloads/cms1479n.pdf MS-DRG Weights, age factors, comorbid factors and los factors (2008) http://www.cms.gov/InpatientPsychFacilPPS/04_tools.asp#TopOfPage Comorbid dgns groups (2008) http://www.cms.gov/InpatientPsychFacilPPS/04_tools.asp#TopOfPage If PROC_CD = 94.27 and REV_CNTR = 0901 then use REV_CNTR_UNIT_CNT for ECT Units. The outlier labor portion (.76) was confirmed by CMS.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Other Inpatient	**Inpatient claims remaining**		
CAH Claims	Critical access hospital claims	The standardized payment is actual payment amount on the claim.	
	NCH_CLM_TYPE_CD = 60, 61 and Substr(PROVIDER_ID,3,2) = 13	STD_PMT_AMT = CLM_PMT_AMT	The NCH_CLM_TYPE_CD and PROVIDER_ID values are from the ResDAC website.
Other Inpatient Claims	All other inpatient claims.	The standardized payment is actual payment amount on the claim.	
	NCH_CLM_TYPE_CD = 60, 61 and not in any of above classifications	STD_PMT_AMT = CLM_PMT_AMT	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Skilled Nursing Facility (SNF)	**SNF claims**		
	NCH_CLM_TYPE_CD = 20, 30		The NCH_CLM_TYPE_CD are from the ResDAC website.
Non Swing Bed	All non swing-bed SNF claims.	The standardized payment is computed as the per diem base payment amount times the revenue center unit count, where the non rehab per diem base rate equals the nursing base rate times the nursing weight plus the non rehab base rate plus the other base and the rehab per diem base rate equals the nursing base times the nursing weight plus the rehab base rate times the therapy weight plus the other base rate.	

	The base claim record links with a revenue center record with REV_CNTR = 0022.	STD_PMT_AMT =
		PER_DIEM base rate*rev_cntr_unit_cnt
		Where
		If the RUG is a Non-Rehab RUG then
		PER_DIEM base rate = Nursing base * NURSING_WGT + Non-Rehab base+ Other base
		Else
		PER_DIEM base rate = Nursing base * NURSING_WGT + Rehab base * THERAPY_WGT+ Other base
		
		If any claim has 1st 3 characters of dgns_cd1-10 = '042' then STD_PMT_AMT=STD_PMT_AMT * 1.28
			UnAdj Base Rates
			(2008) – Table 2 & Table 3
			http://edocket.access.gpo.gov/2007/pdf/07-3784.pdf
			
			Nursing base= 146.62(U) 140.08(R), Average=143.35
			Non-Rehab base= 14.54(U) 15.54(R), Average=15.04
			Rehab base= 110.44(U) 127.35(R), Average=118.895
			Other base= 74.83(U) 76.21(R), Average=75.52
			
			RUG Weights (2008)
			(Table 4)
			http://edocket.access.gpo.gov/2007/pdf/07-3784.pdf
			
			RUG = Substr(HCPCS_CD,1,3) when REV_CNTR = 0022
			
			The first 3 char of any dgns_cd equal to 042 qualifies for 128% HIV adjustment.

Swing Bed	All swing-bed SNF claims.	The standardized payment is the actual payment.	
	The base claim record does not link with a revenue center record with REV_CNTR = 0022.	STD_PMT_AMT = CLM_PMT_AMT	These claims are typically associated with Critical Access Hospitals.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Home Health Agency (HHA)	**HHA claims**		
	NCH_CLM_TYPE_CD = 10		NCH_CLM_TYPE_CD are from the ResDAC website.
Short Stay Outliers	Claims where there is more than 1 line item per claim with an HHRG revenue center code or discharge status of discharged or transferred to home care of organized home health service organization, or HHA visit count is less than 5.	The standardized payment is estimated as the Medicare payment amount on the claim divided by the percent attributed to labor and capital times the wage index plus the percent attributed to non-labor.	
	REV_CNTR = 0023 more than once on a single claim Or PTNT_DSCHRG_STUS_CD = '06' Or CLM_HHA_TOT_VISIT_CNT < 5	STD_PMT_AMT = CLM_PMT_AMT / (WAGE_INDX * 0.77082 + 0.22918)	Home health market basket: Labor portion for 2008 is 0.77082 http://www.cms.gov/apps/media/press/factsheet.asp?Counter=2409&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date
Others Claims	All other HHA claims.	The standardized payment is computed as the base payment amount times the HIPPS weight plus the high-cost outlier payment amount plus the pass-through add-ons.	
		STD_PMT_AMT = (2270.32) * HIPPS_WGT + OUTLIER +Add On Where HIPPS_WGT is the weight corresponding to the HHRG when REV_CNTR = 0023 HHRG = Substr(APC_HIPPS,2,3) if populated else HHRG = Substr(HCPCS_CD,2,3) and OUTLIER=CLM_VAL_AMT / (WAGE_INDX* 0.77668 + 0.22332) when VAL_CD = 17 and Add On = REV_CNTR_PMT_AMT when REV_CNTR = 0274 prosthetics REV_CNTR = 029* DME REV_CNTR = 060* oxygen	Episode Base Rate (2008) - National 60 Day Episode rate http://www.cms.gov/apps/media/press/factsheet.asp?Counter=2409&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date HHRG Weights – new hipps codes for 2008 (need 1st 4 bytes of hcpcs_cd to link to schedule). Used 2007 schedule for the 11.5% that still had old codes (need the middle 3 bytes of hcpcs_cd to link to schedule). http://www.cms.hhs.gov/HomeHealthPPS/Downloads/HIPPSCodesWeighted.zip Wage_Index is based on the beneficiary CBSA from the value code table. If VAL_CD = 61, then CBSA = CLM_VAL_AMT

HHA (cont.)	**HHA claims**		The cbsa to wage_index crosswalks on the CMS website for irf, ltc, ipf and hha were nearly equal. Irf was used because it seemed to be the most comprehensive. We created wage2008.sas7bdat and uploaded to UNIX. Note – This is beneficiary to CBSA, not provider to CBSA as in some of the other service settings (e.g., Acute).

Setting	Selection Criteria	2008 Standardized Payment Computations	References/Comments
Hospice	**Hospice claims**		
	NCH_CLM_TYPE_CD = 50		The NCH_CLM_TYPE_CD are from the ResDAC website.
Claims for physician services	Claims where revenue center code equals 0657 which identifies hospice charges for services furnished to patients by physician or nurse practitioners.	The standardized payment is the actual payment.	
	REV_CNTR = '0657'	STD_PMT_AMT = clm_pmt_amt	
Claims for continuous home care (CHC)	Claims where revenue center code equals 0652 (CHC)	The standardized payment is computed as the base payment amount times the unit count.	
	REV_CNTR = '0652'	STD_PMT_AMT=base*UNIT_CNT/24 Where base rate 0652 = 788.55(Q1-Q3) and 817.26 (Q4) (CHC) And UNIT_CNT=min(rev_cntr_unit_cnt/4,24)	UnAdj Base Rates Oct 1, 2007-Sept 30, 2008 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5685.pdf Oct 1, 2008 – Sept 30,2009 http://www.cms.gov/Hospice/downloads/hospicerates09.pdf
Other Claims	Claims where revenue center code equals 0651 (RHC), 0655 (IRC), 0656 (GIC)	The standardized payment is computed as the base payment amount times the unit count.	
	REV_CNTR in (0651,0655,0656)	STD_PMT_AMT = base*UNIT_CNT Where base rate 0651 = 135.11(for Q1-Q3) 140.15 (Q4)(RHC) and base rate 0655 = 139.76(for Q1-Q3) 152.41 (Q4) (IRC) and base rate 0656 = 601.02(for Q1-Q3) 622.66 (Q4) (GIC) and UNIT_CNT= min(rev_cntr_unit_cnt,los) and LOS= clm_thru_dt–clm_from_dt + 1	UnAdj Base Rates Oct 1, 2007-Sept 30, 2008 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5685.pdf Oct 1, 2008 – Sept 30,2009 http://www.cms.gov/Hospice/downloads/hospicerates09.pdf

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Rural or Federally Qualified Health Center (RHC) (FQHC)	**RHC and FQHC claims**		
	NCH_CLM_TYPE_CD = 40 and (clm_fac_type_cd='7' and clm_srvc_clsfctn_type_cd='1')(RHC) or (clm_fac_type_cd='7' and clm_srvc_clsfctn_type_cd='3')(FQHC)		The clm_fac_type_cd, clm_srvc_clsfctn_type_cd and NCH_CLM_TYPE_CD are from the ResDAC website.
All Claims	All RHC/FQHC claims	The standardized payment is the actual payment amount.	
		STD_PMT_AMT = clm_pmt_amt	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Hospital Outpatient (HOP)	**HOP claims**		
	NCH_CLM_TYPE_CD = 40 and not RHC or FQHC		The NCH_CLM_TYPE_CD are from the ResDAC website.
Pass-Through Claims	Pass-through drugs, biological and other devices	The standardized payment is the actual payment amount.	
	Status_Indicator in (G, H)	STD_PMT_AMT = clm_pmt_amt	Status Indicator (2008) http://www.cms.gov/quarterlyproviderupdates/downloads/cms1392fc.pdf p. 66824
Maryland Claims	Claims for outpatient services in Maryland acute care facilities.	Same computation as for acute Maryland claims.	
	Substr(PROVIDER_ID,1,4) = 2100	STD_PMT_AMT = MEDICARE_PMT_AMT / (.6*Wage_Index + .4) Where Wage_Index is based on the provider CBSA and MEDICARE_PMT_AMT = CLM_PMT_AMT	Deductible is included in the MD CLM_PMT_AMT
Outpatient ER Services	Hospital outpatient claims for ER services	The standardized payment is amount on the APC Fee Schedule, PFS or Lab Fee Schedule.	
	REV_CNTR in ('0450','0451','0452','0456','0459')	STD_PMT_AMT = Fee Schedule Amt Where Fee Schedule (APC, PFS or Lab) amount corresponds to the HCPCS_CD (and MOD for PFS or Lab) If NAT_LIM_AMT = 0 the STD_PMT_AMT = CLM_PMT_AMT	APC Fee Schedule (2008) – CMS-1392-FC. Addendum B http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=dual,%20data&filterValue=2008&filterByDID=3&sortByDID=3&sortOrder=descending&itemID=CMS1204971&intNumPerPage=10
All Other Claims	Other hospital outpatient claims	The standardized payment is amount on the APC Fee Schedule, PFS or Lab Fee Schedule plus the high-cost outlier payment amount.	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
HOP (cont.)	**HOP claims**		
		REV_PMT_AMT = Fee Schedule Amt Where Fee Schedule (APC, PFS or Lab) amount corresponds to the HCPCS_CD (and MOD for PFS or Lab) If NAT_LIM_AMT = 0 the STD_PMT_AMT = CLM_PMT_AMT STD_PMT_AMT = Sum of REV_PMT_AMT + OUTLIER Where OUTLIER = CLM_VAL_AMT / (wage_indx * .6 + .4) when VAL_CD = 17	APC Fee Schedule: (2008) CMS-1392-FC. Addendum B http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=dual,%20data&filterValue=2008&filterByDID=3&sortByDID=3&sortOrder=descending&itemID=CMS1204971&intNumPerPage=10 The labor portion (.6) was verified by CMS. National Unadjusted Copayment is used when populated. When National Unadjusted Copayment is not populated, Minimum Unadjusted Copayment is used for the coinsurance amount.
Multiple and Interrupted Procedures	Multiple and interrupted revenue center procedures	Reduce standardized payment by 50%.	
	Status_Indicator = T (Multiple) Or Modifier_Cd in (52,73) (Interrupted)	REV_PMT_AMT = REV_PMT_AMT * 0.50	Not applied to pass-through claims or acute facility Maryland claims.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Coinsurance and Deductible Adjustment	**PTA standardized payments are adjusted for coinsurance deductibles**		
	No adjustment for Hospice, HHA, Critical Access, FQHC/RHC or when the STANDARD_PMT is simply a multiple of the actual payment.	Adjusted payment for Acute, LTC, IRF, IPF and SNF = STANDARD_PMT - NCH_BENE_IP_DDCTBL_AMT - NCH_BENE_PTA_COINSRNC_LBLTY_AMT Adjusted payment for OP: If APC: if national_unadjusted_copayment_~=. then STANDARD_PMT = (FEE_SCHEDULE_AMT-REV_CNTR_CASH_DDCTBL_AMT)* (1 - (NATIONAL_UNADJUSTED_COPAYMENT/FEE_SCHEDULE_AMT)) Else STANDARD_PMT = (FEE_SCHEDULE_AMT-REV_CNTR_CASH_DDCTBL_AMT)* (1-(MINIMUM_UNADJUSTED_COPAYMENT/FEE_SCHEDULE_AMT)) If not APC: STANDARD_PMT = (FEE_SCHEDULE-REV_CNTR_CASH_DDCTBL_AMT)*.8	Zero clm_pmt_amt's will have standard_pmt and adjusted_pmt equal to null.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Ambulatory Surgical Center (ASC)	**ASC claims**		
	NCH_CLM_TYPE_CD in (71,72) and CARR_LINE_TYPE_SRVC_CD = F		The NCH_CLM_TYPE_CD and CARR_LINE_TYPE_SRVC_CD values are from the ResDAC website.
ASC Claims	Ambulatory Surgical Center services.	The standardized payment is computed from the ASC Fee Schedule.	
		Merge the line item with the ASC Fee Schedule by HCPCS_CD to get ASC_PMT STD_PMT_AMT = ASC_PMT	ASC Fee Schedule (2008) – CMS-1392-FC. Addendum AA & BB http://www.cms.gov/ASCPayment/ASCRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1213395&intNumPerPage=10
Multiple and Interrupted Procedures	Multiple and interrupted revenue center procedures	Reduce standardized payment by 50%.	
	Modifier_Cd = 51 (Multiple) Or Modifier_Cd in (52,73) (Interrupted)	STD_PMT_AMT = STD_PMT_AMT * 0.50	Concatenate addendum AA (Add AA_ January08 ASC Surgical Procedures.xls) and BB (Add BB_ January08 ASC Drug and Ancillary.xls) and merge to claims by HCPCS_CD.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Durable Medical Equipment (DME); Prosthetic, Orthotics, Surgical (POS) and Parenternal/ Enternal (PEN)	**DME, POS, and PEN claims**		
	NCH_CLM_TYPE_CD in (71,72,81,82)		The NCH_CLM_TYPE_CD are from the ResDAC website.
PO Claims	Prosthetic, orthotics and therapeutic shoe claims.	The standardized payment is 5/6 the amount on the DMEPOS Fee Schedule.	
	BETOS_CD in (D1A,D1B,D1C,D1D,D1E,D1F) and CATG in (PO,TS)	If HCPCS_1ST_MDFR_CD in ('AU','AV','AW','KF','KM','KN','NU','RR','UE') then MOD=HCPCS_1ST_MDFR_CD If HCPCS_2ND_MDFR_CD in ('KF','KC','BA') then MOD2=HCPCS_2ND_MDFR_CD Merge the line item with the DMEPOS Fee Schedule by HCPCS_CD, MOD and MOD2 to get DME_CEILING STD_PMT_AMT = (5/6)*DME_ CEILING	DMEPOS Fee Schedule (2008) – zip file. Concatenate dme and pen http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1212231&intNumPerPage=10 If ceiling=0 then ceiling=average of the state payments.
DME/S Claims	Durable Medical Equipment and surgical dressing claims.	The standardized payment is the amount on the DMEPOS Fee Schedule.	
	BETOS_CD in (D1A,D1B,D1C,D1D,D1E,D1F) and CATG not in (PO,TS)	STD_PMT_AMT = DME_ CEILING	If ceiling=0 then ceiling=average of the state payments.
PEN Claims	Parenteral and Enteral claims.	The standardized payment is the amount of the claim since there is no area adjustment.	
	BETOS_CD = O1C	STD_PMT_AMT = CLM_PMT_AMT	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Drug	**Part B Drug claims**		
	NCH_CLM_TYPE_CD in (71,72,81,82)		The NCH_CLM_TYPE_CD are from the ResDAC website.
PTB Drug Claims	DME, imaging and other PTB drugs	The standardized payment is the amount on the Drug Fee Schedule times the unit count.	
	BETOS_CD in (D1G,I1E,I1F,O1D,O1E,O1G)	Merge the line item with the Drug Fee Schedule by HCPCS_CD to get DRUG_PMT STD_PMT_AMT = DRUG_PMT * ****_LINE_MTUS_CNT Where ****_LINE_MTUS_CNT = CARR_LINE_MTUS_CNT or DMERC_LINE_MTUS_CNT whichever is populated	Drug Fee Schedule (2008) – use last quarter schedule as was done for 2007 http://www.cms.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp#TopOfPage

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Lab	**Clinical Lab claims**		
	NCH_CLM_TYPE_CD in (71,72)		The NCH_CLM_TYPE_CD are from the ResDAC website.
Lab Tests	Claims for lab tests	If the National Limit amount on the Lab Fee Schedule is zero then the standardized payment is the amount on the claim, else the standardized payment is National Limit amount.	
	BETOS_CD = T1*	If HCPCS_1ST_MDFR_CD = QW or HCPCS_2ND_MDFR_CD = QW then MOD = QW Merge the line item with the Lab Fee Schedule by HCPCS_CD and MOD to get NAT_LIM_AMT If NAT_LIM_AMT = 0 then STD_PMT_AMT = CLM_PMT_AMT Else if HCPCS in (83898,83904) then STD_PMT_AMT = CARR_LINE_MTUS_CNT*NAT_LIM_AMT Else STD_PMT_AMT = NAT_LIM_AMT	Lab Fee Schedule (2008) – 08CLAB.ZIP http://www.cms.gov/ClinicalLabFeeSched/02_clinlab.asp#TopOfPage Do not change national limit if it equals 0. Apply MTUS count multipliers for 2 HCPCS codes (83898, 83904) only.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Ambulance (AMB)	**AMB Claims**		
	NCH_CLM_TYPE_CD in (71,72)		The NCH_CLM_TYPE_CD are from the ResDAC website.
AMB	Ambulance claims	For mileage codes the standard payment is the amount on the claim. For other ambulance codes the standard payment is the arithmetic mean of the claim amounts for the code.	
	BETOS_CD = O1A	If HCPCS_CD in ('A0425','A0435','A0436'), then STD_PMT_AMT = CLM_PMT_AMT Else if HCPCS_CD in ('A0426' ,'A0427' ,'A0428' ,'A0429' ,'A0430' ,'A0431' ,'A0432' ,'A0433' ,'A0434'), then STD_PMT_AMT = the arithmetic mean of CLM_PMT_AMT by HCPCS_CD.	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Anesthesia (ANES)	**ANES Claims**		
	NCH_CLM_TYPE_CD in (71,72)		The NCH_CLM_TYPE_CD are from the ResDAC website.
ANES	Anesthesia claims	The standardized payment is computed as the base unit plus additional 15 minute time units multiplied by the conversion factor.	
	BETOS_CD = P0 And CARR_LINE_MTUS_CD = 2	Standard Pmt = (BASE+CARR_LINE_MTUS_CNT/10)*conversion factor of 19.9698 Merge the claims with the Base Unit file by HCPCS.	Anesthesia Conversion Factor from CMM 2008 Anesthesia Conversion Factor – CMS-1385-FC , use published version and find Anesthesia Fee Schedule Conversion Factor http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp?intNumPerPage=20&listpage=1 2008 Anesthesia Base Units by CPT code http://www.cms.gov/center/anesth.asp Time Unit: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf
Multiple Procedures and CRNA Procedures	Anesthesia claims involving two or more procedures or for monitoring a CRNA	Reduce standardized payment by 50%.	
	Modifier_Cd in (QK-Multiple, QX-CRNA, QY-CRNA)	STD_PMT_AMT = STD_PMT_AMT * 0.50	CRNA Modifiers: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf For QK - Section 50, C. For QS, QX, QZ, QY - Section 140.4.2

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Medicare Physician Fee Schedule (MPFS)	**MPFS claims**		
	NCH_CLM_TYPE_CD in (71,72,81,82)		The NCH_CLM_TYPE_CD are from the ResDAC website.
Physician Claims	All carrier claims not identified above that link to a non-zero payment amount on the MPFS	Merge the claims not satisfying the criteria for other settings with the MPFS by HCPCS and Modifier. If the service was performed in a facility use the facility fee schedule amount for the standardized payment, otherwise use the non-facility amount.	

		If HCPCS_CD in ('45378','G0105','G0121') and (HCPCS_1ST_MDFR_CD ='53' or HCPCS_2ND_MDFR_CD='53') then MOD='53';
		Else if (HCPCS_1ST_MDFR_CD in ('QW','26','TC') then MOD=HCPCS_1ST_MDFR_CD
		Else if (HCPCS_2ND_MDFR_CD in ('QW','26','TC') then MOD=HCPCS_2ND_MDFR_CD
		
		Merge the claims with the MPFS by HCPCS_CD and MOD. The merge will link 2 payment fields, FAC and NON_FAC (facility and non-facility). It will also link a MULTI_PROC (multi procedure) indicator.
		
		If LINE_PLACE_OF_SRVC_CD in ('21','22','23','24','31','51') then
		STD_PMT_AMT = FAC (facility pmt)
		Else
		STD_PMT_AMT = NON_FAC (non-facility pmt)
			RVU files for pfs – PPRVU08
			http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=3
			
			Std Pmt = (Round(work RVU · .8994,2) + Transitioned PE RVU + MP RVU) *conversion factor

Non-physician Procedures	Services performed by PAs, NPs, etc.	Reduce standardized payment by amount indicated.	
	Pas, NPs, CNS, Registered Dietitians/Nutritionists PRVDR_SPCLTY_CD in (97,50,89,71) Certified Nurse Midwife PRVDR_SPCLTY_CD in (42) Clinical Social Worker PRVDR_SPCLTY_CD in (80)	If PRVDR_SPCLTY_CD in (97,50,89,71) then STD_PMT_AMT = STD_PMT_AMT * 0.85 Else if PRVDR_SPCLTY_CD in (42) then STD_PMT_AMT = STD_PMT_AMT * 0.65 Else if PRVDR_SPCLTY_CD in (80) then STD_PMT_AMT = STD_PMT_AMT * 0.75	The PRVDR_SPCLTY_CD are from the ResDAC website.
Multiple Procedures	Physician claims involving ≥ two procedures	Reduce standardized payment by 50%.	
	Modifier_Cd = 51 and MULTI_PROC = 2	STD_PMT_AMT = STD_PMT_AMT * 0.50	Apply this reduction even if the specialty is a non-physician specialty.

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Other Carrier	**Other Carrier claims**		
	NCH_CLM_TYPE_CD in (71,72,81,82)		The NCH_CLM_TYPE_CD are from the ResDAC website.
Other Claims	All carrier claims not identified above	The standardized payment is the actual payment amount.	
		STD_PMT_AMT = CLM_PMT_AMT	

Setting	Selection Criteria	Standardized Payment Computations	References/Comments
Coinsurance and Deductible Adjustment	**PTB standardized payments are adjusted for coinsurance deductibles**		
	No adjustment for ambulance or when the STANDARD_PMT is simply a multiple of the actual payment.	COINS (coinsurance) = LINE_COINSRNC_AMT / (LINE_ALOWD_CHRG_AMT - LINE_BENE_PTB_DDCTBL_AMT) Adjusted Payment = (STD_PMT_AMT - LINE_BENE_PTB_DDCTBL_AMT) * (1 - COINS)	In general, the COINS computation is 20%. So the Adjusted Payment is the Standard Payment minus the Deductible minus the Coinsurance, which is approximately 20% of the difference between the Standard Payment and the Deductible. Zero clm_pmt_amt's will have standard_pmt and adjusted_pmt equal to null.