



Form CMS-2552-96 Update Transmittals 20 and 21

Don Fry, Director, KPMG LLP, Los Angeles, CA

Joe Sellars, Director, KPMG LLP, Jacksonville, FL

New York ICR Road Shows

April 12-16, 2010

Summary of effective dates and significant changes

COMMON TO BOTH:

- ◆ The effective dates for instructional changes vary due to various implementation dates.

TRANSMITTAL 20

- ◆ Changes to the electronic cost reporting specifications are effective for cost reporting periods ending on or after May 31, 2009.
- ◆ Transmittal 20 reflects further clarification to existing instructions and incorporates select provisions of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 and the American Recovery and Reinvestment Act (ARRA) of 2009.

TRANSMITTAL 21

- ◆ Changes to the electronic cost reporting specifications are effective for cost reporting periods ending on or after October 1, 2009.
- ◆ Transmittal 21 reflects further clarification to existing instructions and incorporates select provisions of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 and IPPS Final Rule issued in the Federal Register, August 28, 2009.

Transmittal 20 – Significant Revisions

- ◆ Revised Worksheet S-2 questions to provide for the extension of TOPPS payments for qualifying hospitals.
- ◆ Removed physician information from Worksheet S-8.
- ◆ Added a new cost center to identify generally high cost implantable medical devices chargeable and traceable to specific patients.
- ◆ Revised Worksheet E, Part A, line 5.05 with the updated average cost per dialysis of \$401.43. That is \$133.81 times the average number of treatments (3) per week.
- ◆ Removed the 50 percent reduction (previously implemented in T19) applied to capital IME for fiscal year 2009 in accordance with the American Recovery and Reinvestment Act of 2009 (AARA 2009), section 4301(b). This gives the provider the full capital IME amount for discharges occurring on or after October 1, 2008 through September 30, 2009. See CR 6444, transmittal 466, dated March 27, 2009.

Worksheet S-2, Lines 21.06 and 21.07

21.06	Does this hospital qualify for the three -year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147? (See instructions). Enter "Y" for yes, and "N" for no.			21.06
21.07	Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA§147? Enter "Y" for yes and "N" for no.(See instructions)			21.07

Line 21.06 - MIPPA, section 147 extends the hold harmless payments for small rural hospitals with 100 or fewer beds for services rendered from January 1, 2009 through December 31, 2009.

Line 21.07 - MIPPA, section 147 provides for hold harmless payments for hospitals qualifying as a SCH with 100 or fewer beds for services rendered from January 1, 2009 through December 31, 2009.

These responses impact the TOPPS calculation on Worksheet E, Part B, Line 1.06.

Worksheet S-8, Lines 9 and 10

Physician Information:		Physician name	Billing No.	
9	Physician(s) furnishing services at the clinic or under agreement (see instructions)			9
		Physician name	Hours	
10	Supervisory physician(s) and hours of supervision during period (see instructions)			10

Worksheet S-8, Part II - Lines 9 and 10 are not applicable effective for cost reporting periods ending on or after May 31, 2009.

Worksheet A, Line 55.30

55	5500	Medical Supplies Charged to Patients								55
55.30	5530	Implantable Devices Charged to Patients								55.30
56	5600	Drugs Charged to Patients								56

New cost center added for implantable devices charged to patients effective for cost reporting periods beginning on or after May 1, 2009.

The types of items includable on this line are high cost implantable devices that remain in the patient upon discharge, and are chargeable and traceable to individual patients. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned.

Worksheet E, Part A

3690 (Cont.)		CMS FORM-2552-96		11-08
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.: 14-0634	PERIOD: FROM 5/01/2009 TO 4/30/2010	WORKSHEET E, PART A (Cont.)
		COMPONENT NO.: 14-0634		
Check	<input type="checkbox"/> Hospital			
Applicable Box	<input type="checkbox"/> Subprovider			
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		Period	Period	
		5/1/2009 - 12/31/2009	1/1/2010 - 4/30/2010	
		1	1.01	
Additional payment for high percentage of ESRD beneficiary discharges				
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 MS-DRGs 683 and 684. (see instructions)	500		5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, 317, MS-DRGs 683, and 684 (see instructions)	40	12	5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)	10.40%		5.02
5.03	Total Medicare ESRD inpatient days excluding DRGs 302, 316, 317, MS-DRGs 683, and 684.(see instructions)	500		5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)	1.373626		5.04
5.05	Average weekly cost for dialysis treatments (see instructions)	401.43	405.44	5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)	28,740		5.06
6	Subtotal (see instructions)	9,546,803		6

Average weekly cost for dialysis treatments on line 5.05 is subject to change on an annual basis.

Worksheet E, Part A

3690 (Cont.)		CMS FORM-2552-96		11-08	
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.: 14-0634	PERIOD: FROM 5/01/2009 TO 4/30/2010	WORKSHEET E, PART A (Cont.)	
Check <input type="checkbox"/> Hospital Applicable Box <input type="checkbox"/> Subprovider		COMPONENT NO.: 14-0634			
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
Additional payment for high percentage of ESRD beneficiary discharges					
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges MS-DRGs 683 and 684. (see instructions)				5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, 317, MS-DRG				01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)				02
5.03	Total Medicare ESRD inpatient days excluding DRGs 302, 316, 317, MS-D				03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 d				04
5.05	Average weekly cost for dialysis treatments (see instructions)				05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)				06
6	Subtotal (see instructions)		9,546,802		6
7	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instruction		-		7
7.01	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.See instruction		-		7.01
8	Total payment for inpatient operating costs SCH and MDH only (see instructions)		9,546,802		8

MIPPA Section 122 provided SCH's with an option to rebase their HSR using their FY 2006 cost report.

- **Instructional Change**
- **Effective for cost reporting periods beginning on or after 1/1/2009**
- **Use higher of 1982, 1987, 1996 or 2006**

Worksheet L, Part I

	CAPITAL FEDERAL AMOUNT		
2	Capital DRG other than outlier		2
3	Capital DRG outlier payments for services rendered prior to October 1, 1997		3
3.01	Capital DRG outlier payments for services rendered on or after October 1, 1997		3.01
Indirect Medical Education Adjustment			
4	Total inpatient days divided by number of days in the cost reporting period (see instructions)		4
4.01	Number of interns & residents (see instructions)		4.01
4.02	Indirect medical education percentage (see instructions)		4.02
4.03	Indirect medical education adjustment (sum of lines 2 & 3 times line 4.02)		4.03

This transmittal change removes the T19 change which reduced the capital IME by 50 percent for discharges occurring during the period 10/1/2008 through 9/30/2009.

Transmittal 21 – Significant Revisions

- ◆ Revised Worksheet S-2 questions on lines 21.01, 21.08 and 30.03.
- ◆ Worksheet S-3, Part I
 - **Line 26, columns 5 and 6 are revised to reflect the exclusion of observation patient days from the computation of the disproportionate patient percentage (DPP) and from the computation of bed days available for the purpose of computing IME.**
 - **Line 29 was added to separately capture Labor and Delivery days.**
- ◆ As a provider invoked option, nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy are established for use on Worksheet A as identified in Table 5 of the electronic cost reporting (ECR) specifications.

Transmittal 21 – Significant Revisions

- ◆ **Worksheet E, Part A**
 - **The calculation of line 3 is revised to reflect the subtraction of total observation days from the computation of bed days available for the purpose of IME and the calculation of line 4.01 is revised to reflect the exclusion of subsequently admitted observation days from the computation of the DPP in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.**
 - **Line 5.05 is revised to reflect the update of the cost per renal dialysis treatment for the calendar year 2010 (\$135.15) as indicated in change request (CR) 6679, transmittal 113, dated October 30, 2009.**

- ◆ **Worksheet E-3, Part I - Instructions revised for inpatient rehabilitation facilities (IRF) to reflect the update for the low income patient (LIP) adjustment factor and the medical education adjustment factor both effective for discharges on or after October 1, 2009 in accordance with the Federal Register, volume 74, number 151, dated August 7, 2009, page 39774.**

Transmittal 21 – Significant Revisions

- ◆ Worksheet L, Part I - Section is revised to reinstate the full capital IME teaching adjustment factor (previously addressed in T20) applied for fiscal year 2009 and subsequent in accordance with the Federal Register, volume 74, number 165, dated August 27, 2009, page 43929, giving providers the full capital IME teaching amount for discharges occurring on or after October 1, 2008.
- ◆ Worksheet M-3 - Line 14 is revised to implement section 102 of Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 for rural health clinics (RHCs) and Federally qualified health centers (FQHCs), to phase out the outpatient mental health treatment limitation over the 5 year period from 2010 through 2014.
- ◆ Worksheet M-4 - Columns 2.01 and 2.02 are added to capture relevant data and calculate the costs of H1N1 influenza vaccines; and the simultaneous administration of H1N1 influenza and seasonal influenza vaccines and administration.

Worksheet S-2, Line 21.01

Other Information				
21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.			21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106? <i>Enter in column 1 "Y" for yes or "N" for no.</i> <i>Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)?</i> <i>Enter in column 2 "Y" for yes or "N" for no.</i>			21.01

Line 21.01 is amended to ascertain if providers that qualify for disproportionate share (DSH) payments are also subject to the "Pickle Amendment." (Effective for cost reports beginning on or after 10/1/2009)

Worksheet S-2, Line 21.08

21.08	<i>Which method is used to determine Medicaid days on S-3, Part I, col. 5? Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceding cost reporting period? Enter in column 2, "Y" for yes or "N" for no.</i>				21.08
-------	--	--	--	--	-------

Line 21.08 has been added to identify the method of accumulating the day count (including labor/delivery days) for Title XIX and total days to refine the calculation for DSH payments in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43899, effective for cost reporting periods beginning on or after October 1, 2009.

Worksheet S-2, Line 30.03

30.03	If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000).			30.03
-------	---	--	--	-------

Line 30.03 is eliminated effective for cost reporting periods beginning on or after October 1, 2009, as critical access hospitals (CAHs) will complete Worksheet D, Part V, line 65 only for ambulance services that were billed as exempt from the ambulance fee schedule as indicated in the provider's accounting books and records or the Provider Statistical and Reimbursement (PS&R) report type 85C.

Worksheet S-3, Part I, Line 26

Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips						Total All Patients	Obs. Beds Admitted	Obs. Beds Not Adm
			Title V	Title XVIII	Title XIX		Total Title XIX				
					Obs. Beds Admitted	Obs. Beds Not Adm					
1	2	3	4	5	5.01	5.02	6	6.01	6.02		
23 Outpatient Rehab. Provider (specify)											
24 RHC/FQHC (specify)											
25 Total (sum of lines 12-24)											
26 Observation Bed Days											
27 Ambulance Trips											
28 Employee discount days (see instru.)											
29 Labor & delivery days (see instructions)											

Worksheet S-3, Part I - Line 26, columns 5 and 6 are revised to reflect the exclusion of observation patient days from the computation of the disproportionate patient percentage (DPP) and from the computation of bed days available for the purpose of computing indirect medical education (IME) in accordance with the Federal Register, volume 74, number 165, date August 27, 2009, page 43905, effective for cost reporting periods beginning on or after October 1, 2009.

Worksheet S-3, Part I, Line 29 (new line)

Line 29--Indicate in column 5 the count of labor/delivery days for Title XIX and in column 6 the total count of labor/delivery days for the entire facility.

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see PRM-1, section 2205.2).

In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) room, hospitals must determine the proportion of each I/P stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (post partum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 29. Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 29. These days must not be reported on Worksheet S-3, Part I, line 1 or line 12.

Worksheet E, Part A, Line 3

2	Outlier payments for discharges occurring prior to October 1, 1997 (see instructions)		2
2.01	Outlier payments for discharges occurring on or after October 1, 1997 (see instructions)		2.01
3	Bed days available divided by number of days in the cost reporting period (see instructions)		3
Indirect Medical Education Adjustment			
3.01	Number of Interns & Residents from Worksheet S-3, Part I		3.01
3.02	Indirect medical education percentage (see instructions)		3.02

Line 3--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 2, line 12) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26 for cost reporting periods beginning before October 1, 2004 and beginning on or after October 1, 2009 or Worksheet S-3, Part I, column 6.02, line 26 for cost reporting periods beginning on or after October 1, 2004 and beginning before October 1, 2009).

Worksheet E, Part A, Line 4.01

Additional payment for high percentage of ESRD beneficiary discharges			
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 or MS-DRG 652, 682 - 685. (see instructions)		5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, 317, or MS-DRGs 652 and 682 - 685 (see instructions)		5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)		5.02
5.03	Total Medicare ESRD inpatient days excluding DRGs 302, 316, 317, or MS-DRGs 652, 682 - 685.(see instructions)		5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)		5.04
5.05	Average weekly cost for dialysis treatments (see instructions)		5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)		5.06

Line 5.02--Divide line 5.01, sum of columns 1 and 1.01 by line 5, sum of columns 1 and 1.01. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317 or effective October 1, 2007, MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01, sum of columns 1 and 1.01, and divide the result by 7 days.

Line 5.05--Enter the average weekly cost per dialysis treatment of \$401.43 (\$133.81 times the average weekly number of treatments (3)). See CR 6216, Transmittal 98, dated December 12, 2008. See CR 6679, Transmittal 113, dated October 30, 2009 for the calendar year 2010 rate per treatment of \$135.15. This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Worksheet E-3, Part I - IRF

Inpatient Rehabilitation Facility (IRF)			
1.35	Unweighted intern and resident FTE count for cost report periods ending on/for prior to November 15, 2004. (see inst.)		1.35
1.36	New Teaching program adjustment. (see instructions)		1.36
1.37	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		1.37
1.38	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		1.38
1.39	Intern and resident count for IRF PPS medical education adjustment (see instructions)		1.39
1.40	Average Daily Census (see instructions)		1.40
1.41	Medical Education Adjustment Factor <i>(see instructions)</i>		1.41
1.42	Medical Education Adjustment (line 1.02 multiplied by line 1.41).		1.42

Line 1.02 - In accordance with the Federal Register, volume. 74, number 151, page 39774, dated August 7, 2009, effective for IRF discharges rendered on or after October 1, 2009, subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2009 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2009 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2009. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2009.

Line 1.04 - In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the IRF LIP payment formula is updated. For cost reporting periods that overlap October 1, 2009, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2009, enter in column 1 the result of $\{(1 + (\text{line 1.03}) + (\text{L2}/\text{L3})) \text{ to the } .6229 \text{ power} - 1\}$ times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2009, enter in column 1.01 the result of $\{(1 + (\text{line 1.03}) + (\text{L2}/\text{L3})) \text{ to the } .4613 \text{ power} - 1\}$ times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2009. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2009, enter in column 1 the result of $\{(1 + (\text{line 1.03}) + (\text{L2}/\text{L3})) \text{ to the } .4613 \text{ power} - 1\}$ times line 1.02. Not applicable for LTCH.

Worksheet E-3, Part I – IRF (Continued)

Line 1.41--For discharges prior to October 1, 2009, enter in column 1 the medical education adjustment factor by adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012 \text{ power} - 1\}$.

In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the medical education adjustment factor has been updated making it necessary to subscript column 1 for lines 1.41 and 1.42 for cost reporting periods that overlap October 1, 2009.

Calculate the medical education adjustment factor for discharges prior to October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012 \text{ power} - 1\}$. To calculate the medical education adjustment factor for discharges on or after October 1, 2009, enter in column 1.01 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .6876 \text{ power} - 1\}$. Do not subscript column 1 for lines 1.41 and 1.42 for cost reporting periods beginning on or after October 1, 2009.

Calculate the medical education adjustment factor for cost reporting periods beginning on or after October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .6876 \text{ power} - 1\}$.

Line 1.42--Enter in column 1, the medical education adjustment by multiplying line 1.02, column 1 by line 1.41, column 1. If applicable, enter in column 1.01, the medical education adjustment by multiplying line 1.02, column 1.01 by line 1.41, column 1.01. Add the amounts in columns 1 and 1.01 to line 1.06.

Worksheet L, Part I

4.02	Indirect medical education percentage (see instructions)		4.02
4.03	Indirect medical education adjustment (sum of lines 2 & 3 times line 4.02)		4.03
Disproportionate Share Adjustment			
5	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5
5.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		5.01

Lines 4.02 through 4.03-Reinstatement of IME Adjustment Factor--In accordance with the Federal Register, volume 74, number 165, page 43928, dated August 27, 2009 the full capital IME teaching adjustment is fully reinstated for discharges occurring on or after October 1, 2008. Consequently, line 2 (above) and lines 4.02 through 4.03 shall be completed in accordance with the applicable instructions on this and the following page.

Line 4.02--Enter the result of the following calculation: $\{e.2822 \times \text{line } 4.01 / \text{line } 4\} - 1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 cannot exceed 1.5.

Line 4.03--Multiply line 4.02 by the sum of lines 2 and 3. Do not include line 3.01.

Worksheet L, Part I (Continued)

Line 5.01--For cost reporting periods beginning prior to October 1, 2004 and beginning on or after October 1, 2009, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus Worksheet S-3, Part I, line 29, column 5 for cost reporting periods beginning on or after October 1, 2009), minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 plus Worksheet S-3, Part I, line 29, column 6 for cost reporting periods beginning on or after October 1, 2009) minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28. This amount agrees with the amount reported on Worksheet E, Part A, line 4.01.

For cost reporting periods beginning on or after October 1, 2004, and beginning on or before September 30, 2009, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4, plus column 5.01, line 26) to total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4, plus column 6.01, line 26. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28. This amount agrees with the amount reported on Worksheet E, Part A, line 4.01.

Worksheet M-3

		Calculation of Limit (1)		
		Prior to January 1	On or after January 1	
		1	2	
8	Per visit payment limit (from your intermediary)			8
9	Rate for Program covered visits (see instructions)			9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from intermediary records)			10
11	Program cost excluding costs for mental health services (line 9 x line 10)			11
12	Program covered visits for mental health services (from intermediary records)			12
13	Program covered cost from mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (line 13 x 62.5%)			14

For services rendered from January 1, 2010 through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Line 14.--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009 the limitation is 62.50 percent; services from January 1, 2010 through December 31, 2011 the limitation is 68.75 percent; services from January 1, 2012 through December 31, 2012 the limitation is 75 percent; services from January 1, 2013 through December 31, 2013 the limitation is 81.25 percent; and services on or after January 1, 2014 the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Worksheet M-4

		PNEUMOCOCCAL	INFLUENZA	H1N1	INFLUENZA H1N1	
		1	2	2.01	2.02	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)					1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time					2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)					3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)					4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)					5
6	Total direct cost of the facility (from Worksheet M-1, column 7, line 21)					6
7	Total overhead (from Worksheet M-2, line 16)					7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)					8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)					9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)					10
11	Total number of pneumococcal and influenza vaccine injections (from your records)					11
12	Cost per pneumococcal and influenza vaccine injection (line 10/ line 11)					12
13	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries					13
14	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)					14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)					15
16	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 19)					16

Worksheet M-4

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Prior to that date all vaccines were reimbursed through the provider based hospital and could not be claimed by the RHC and FQHC. Additionally, only use this worksheet for vaccines rendered to patients who, at the time of receiving the vaccine(s), were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

Effective for services rendered on or after September 1, 2009 the administration of influenza H1N1 vaccines furnished by RHCs and FQHCs is cost reimbursed. However, no cost will be incurred for the influenza H1N1 vaccine as this is provided free of charge to providers/suppliers.

To account for the cost of administering seasonal influenza vaccines, influenza H1N1 vaccines, and/or both vaccines administered during the same patient visit, column 2 is subscripted adding column 2.01 (administration of only H1N1 vaccines) and 2.02 (administration of both the seasonal influenza and H1N1 vaccines during the same patient visit). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall only be represented one time in the appropriate column. Columns 2.01 and 2.02 will not reflect the cost of H1N1 vaccines as it is furnished at no cost to the provider. However, the cost of seasonal influenza vaccines is required in columns 2 and 2.02, line 4.

Questions?

