Basics of Payment Standardization

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Payment standardization is the process of adjusting the allowed charge for a Medicare service to facilitate comparisons of resource use across geographic areas. This allowed charge for a single service, referred to as the Medicare allowed amount, differs to accommodate varying input costs, such as local wages, and to address policy goals, such as add-on payments in under-served geographic areas.[1] The Centers for Medicare & Medicaid Services (CMS) uses payment standardization to assign a comparable allowed amount for the same service provided by different providers and/or in different settings to reveal differences in spending that result only from care decisions and resource use. Payment standardization does the following:

- **Preserves differences that result from health care delivery choices such as the**:
  - setting where the service is provided (e.g., physician office versus outpatient hospital);
  - specialty of healthcare provider who provides the service (e.g., physician versus physician assistant);
  - number of services provided in the same encounter; and
  - outlier cases.
- **Adjusts for geographic differences** in regional labor costs and practice expenses, as measured by hospital wage indexes and geographic practice cost indexes.
- **Adjusts for payments from special Medicare programs** made to hospitals that are not directly related to resource use for the service:
  - graduate medical education (GME) and indirect medical education (IME), and
  - disproportionate share payments (DSH) (for serving a large low-income and uninsured population).

The payment standardization methodology basics are summarized in this document, and full details are available at this QualityNet webpage.[2] The first section provides a general framework of how Medicare Part A and B claims are payment standardized, while the second section describes how payments are standardized for each service type in detail. For additional questions about the payment standardization methodology, please email cms_payment_standardization@acumenllc.com.

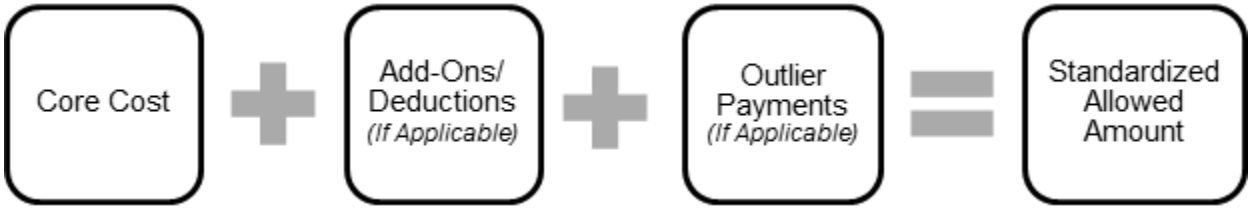
[1] Medicare allowed amount includes Medicare trust fund payments, payments from third party primary payers, and beneficiary deductible and coinsurance.

[2] The CMS document refers to this as "price standardization" rather than "payment standardization," but the two terms are equivalent.

OVERVIEW OF STANDARDIZED ALLOWED CALCULATION

The standardized allowed amount for a service is the sum of the core cost of that service, any add-ons or deductions directly related to resource use, and any applicable outlier payments. The first component, core cost, is the base payment for a service, usually dictated by the product of a fee schedule payment rate and a unit count or service weight. The second component, add-ons or deductions, accounts for payments for supplemental resource use not included in the core cost of a service, such as payments for new technologies used in the inpatient setting. The third component, outlier payment, accounts for excessive costs related to the service provided that are not accounted for by the core cost and add-ons. The calculation of these components differs based on the type of claim and payment system. These three components combine to construct payments that are free of geographic adjustments and special program payments not directly related to resource use. Figure 1 depicts the three components of the standardized allowed amount.

Figure 1. General Payment Standardization Formula



Standardization Approaches

There are three basic methods to calculate the components of the standardized allowed amount for all services. The first method, or Approach A, is used when a service is paid at a national rate, meaning Medicare allowed amounts are uniform across geographic regions. Approach A takes the claim allowed amount, which already contains core costs, add-ons/deductions, and outlier payments, and assigns that amount as the standardized allowed amount. The second method, or Approach B, is used when the service is not paid at a national rate and the standardized allowed amount must be calculated without geographic differences. Approach B constructs core costs, add-ons/deductions, and outlier payments using service-specific payment rates according to their payment rules in such a way that geographic adjustment factors and special program payments not directly related to resource use are excluded. The third approach, or Approach C, is used when the service is not paid at a national rate and there is not enough information available to apply Approach B. Approach C starts with the claim allowed amount and removes regional adjustments and special program payments not directly related to resource use to determine the standardized allowed amount for each service. The following sections explain each method in more detail with appropriate examples.

- ***Approach A: Use Claim Allowed Amount for Services Paid at a National Rate***

For services paid using a uniform national rate, the Medicare allowed amount on the claim is already free of geographic adjustments and special program payments. Thus, the standardized allowed amount is set equal to the Medicare allowed amount paid for the specific claim.

(A.1)

$$Standardized\ Allowed\ Amount = Medicare\ Allowed\ Amount$$

Example: Oxygen Equipment

Oxygen equipment and supplies are paid at a national rate. In 2013, the national rate for renting a liquid oxygen system for 1 month was $177.36, so the standardized allowed amount for such a claim is

$$Standardized\ Allowed\ Amount_{Oxygen\ \ Equipment\ ,2013} = \$177.36$$

where $177.36 is the claim allowed amount and reflects the national rate for this oxygen rental in calendar year (CY) 2013.

- ***Approach B: Calculate Based on Service-Specific Payment Rates***

For services not paid at a national rate, the standardized allowed amount for a claim is calculated by constructing the core costs, add-ons/deductions, and outlier payments using a service-specific payment rate. Depending on the setting, the base payment rate may be specific to a diagnosis related group (DRG), procedure code, or resource utilization group (RUG) as shown in the following equation. These base payment rates are taken from the appropriate fee schedule on the CMS website. When appropriate, the payment rate is multiplied by units such as the number of days in a stay, the number of times the procedure was performed, or the number of units of a product applied.[3] Add-ons, deductions, and outlier payments are also constructed independent of regional multipliers and special program payments unrelated to resource use.

(B.1)

$$\begin{aligned} &Standardized\ Allowed\ Amount \\ &\quad = (Service\ Payment\ Rate \times Applicable\ Units) \\ &\quad + Add\ ons\ or\ Deductions, if\ Applicable + Outlier\ Payments, if\ Applicable \end{aligned}$$

[3] Note that for all services occurring on or after April 1, 2013 and using Approach B, a 2% reduction is applied to the Medicare portion of the allowed amount in the payment standardization calculation to account for the sequester. This sequester adjustment is already accounted for in the Medicare allowed amount of Approaches A and C.

Example: Skilled Nursing Facility (SNF) Services

Traditional SNF services are paid based on a resource utilization group (RUG) specific daily rate determined by CMS each year. Both an urban and rural rate are published for each RUG. The core cost for a traditional three-day SNF stay for low-intensity rehabilitation in FY2013 is standardized as

$$Standarized\ Allowed\ Amount_{3-Day\ Low\ Intensity\ \ Rehab,2013} = \$234.95\ x\ 3 = \$704.85$$

where $234.95 is the average of the urban and rural daily rates for low-intensity rehabilitation in a SNF in FY2013 and units are considered to be the number of days in the stay. In this example there were no add-ons or deductions. Outlier payments are not made on SNF claims.

- ***Approach C: Calculate by Removing Geographic Adjustments from the Claim Allowed Amount***

For services not paid at a national rate and where there is not enough information available to apply Approach B, the payment standardization calculation removes special program payments, such as IME and DSH, and geographic adjustments for wage variance from the allowed amount reported on the claim. The following equation provides a simplified depiction of the Approach C calculation, as used in institutional settings.

(C.1)

$$Standardized\ allowed\ amount = \frac{Medicare\ allowed\ amount - special\ program\ payments}{(labor\ share\ x\ wage\ index) + (1 - labor\ share) \times COLA}$$

In CMS' calculation of the Medicare allowed amount, the labor share represents the proportion of costs that covers salaries and other costs of employment. Specifically, the labor share is the portion of the total cost that is adjusted for regional wage differences while the non-labor share is the portion adjusted for cost of living. Approach C divides the Medicare allowed amount by the product of the labor share, the provider's wage index, the non-labor share, and the cost of living adjustment (COLA) for that state to remove these regional differences.[4]

[4] Approach C incorporates the denominator with these components (COLA, wage index, and labor share) to reverse the calculation performed by the CMS PRICERs for institutional settings.

Example: Skilled Nursing Services at Critical Access Hospitals (CAHs)

The payment standardization methodology for skilled nursing services provided in critical access hospitals (CAHs) calculates a standardized allowed amount by removing geographic and policy adjustments from the claim allowed amount. The standardized allowed amount for a three-day, low-intensity rehabilitation stay in a Fairbanks, Alaska CAH in FY2013 with a Medicare allowed amount of $650 would be calculated as

$$Standardized\ allowed\ amount_{3-day\ low-intensity\ \ rehab\ at\ CAH,2013,Fairbanks\ ,AK} = \frac{\$650 - \$0}{(0.68383\ \times\ 1.0997) + (1 - 0.68383) \times 1.25} = \$566.59$$

where $650 is the allowed amount reported on the claim, $0 is the sum of special program payments, 0.68383 is the FY2013 SNF labor share, 1.0997 is the CAH's wage index, and 1.25 is the cost of living adjustment based on the provider's state. The only states with a COLA greater than one are Alaska and Hawaii; all other states have a COLA of one. In regions where the wage index and COLA are greater than one, the standardized allowed amount is lower than the actual allowed amount. Conversely, when wage index and COLA are less than one, the standardized allowed amount will be greater than the actual allowed amount.

In each approach, the standardized allowed amount is free of geographic adjustments and special program payments not directly related to resource use. Services using Approach A already have such an amount listed on the claim (i.e., claim allowed amount); services using Approach B build up the standardized amount; and services using Approach C work backwards from the claim cost to achieve the standardized amount. The following sections describe each step of the payment standardization calculation and specify which standardization approach is used.

STANDARDIZED PAYMENTS BY SERVICE TYPE

The following sections highlight the methodology for calculating the standardized allowed amount for each of the seven Medicare Part A and B service types: inpatient hospital; outpatient hospital; carrier (physician services); skilled nursing facility (SNF); home health agency; hospice; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).[5] As mentioned in the previous section, the standardized allowed amount for any Medicare claim is calculated based on three components:

1. **Core Costs** based on service-specific payment rates;
2. **Add-ons or Deductions** for additional costs not accounted for in core costs (such as new technologies in an acute inpatient stay) or for reduced-cost care (such as purchasing a used power wheelchair instead of a new one); and
3. **Outlier Payments** for unusually costly care.

The following sections will describe each component as it relates to a specific setting.

A. Inpatient Facilities

Standardization Approaches B and C are used to calculate the standardized allowed amount for inpatient facilities. For the purpose of standardized amount calculation, inpatient services are separated into five different settings: acute care, inpatient psychiatric, inpatient rehabilitation, long term care, and other. Approach B is used to calculate the standardized allowed amount for inpatient services at acute care, inpatient psychiatric, inpatient rehabilitation, and long term care (LTC) hospitals. Approach C is used for LTC shorter-than-average stays, defined as stays where the length of stay is 5/6 of the DRG average or less for DRGs subject to short-stay outlier adjustment. Approach C is also used for other inpatient services which do not fall under the aforementioned categories. The following provides a detailed breakdown of how the core cost, add-on/deductions, and outlier payments are calculated for inpatient services; the details are most relevant for services that are standardized with Approach B. Table 1 summarizes how standardized allowed costs are calculated for all inpatient facilities.

Component 1: Core Cost

Under Approach B, the core cost component is calculated using a base payment rate that is specific to the setting of the inpatient claim and fiscal year, and a weight that is specific to the setting, fiscal year, and DRG. The DRG weight expresses the expected cost of a stay with that

[5] Appendix A outlines each provider type in more detail.

DRG relative to the expected cost of stays in that setting with other DRGs. The following provides a simple example of how the core cost component is calculated under Approach B.

(1)

$$Core\ cost_{inpatient} = setting\ specific\ base\ rate\ x\ DRG\ weight$$

Example: Lung Transplant in an Acute Hospital (Approach B)

The core cost of a lung transplant in an acute care hospital in FY2012 is calculated using the FY2012 acute hospital base rate of $5,631.16 and the FY2012 lung transplant DRG weight of 9.8.

(2)

$$Core\ cost_{lung\ transplant\ at\ acute\ care\ hospital,2012} = \$5{,}631.16\ x\ 9.8 = \$55{,}185.37$$

Component 2: Add-ons or Deductions

When applicable, Approach B includes an add-on for the use of new technology and a deduction for shorter-than-average stays.

Component 3: Outlier Payments

When applicable, Approach B calculates the outlier payment amount given to cover care that is significantly more expensive than expected. Outlier payments in inpatient settings are standardized according to CMS regulations using total covered charges reported by the provider, total payment received for the inpatient stay, a fiscal year- and setting-specific fixed loss threshold, and hospital characteristics.

Table 1. Inpatient Hospital Standardization Components

Inpatient Hospital Type	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Acute Care Hospital[6] *(Acute care, CAH, Maryland, children's, and cancer hospitals)*	Approach B	IPPS base rate multiplied by the IPPS DRG weight	Add-ons for use of new technology and clotting factors Deductions for shorter-than-average stays that end in a transfer and replacement medical device credits	Applied to stays where costs exceed payment beyond a fixed loss threshold
Inpatient Psychiatric Facility (IPF)	Approach B	IPF base rate multiplied by the IPF DRG weight	Add-ons for use of new technology, clotting factors, and electroconvulsive therapy Adjustments for age, comorbidities, length of stay, and replacement medical device credits	Applied to stays where costs exceed payment beyond a fixed loss threshold
Long-Term Care Hospital (LTCH)	Approach B	LTC base rate multiplied by the LTC DRG weight	Add-ons for use of new technology and clotting factor Deductions for shorter-than-average stays and replacement medical device credits	Applied to stays where costs exceed payment beyond a fixed loss threshold
Inpatient Rehabilitation Facility (IRF)	Approach B	IRF base rate multiplied by the IRF DRG weight	Add-ons for use of new technology and clotting factors Deductions for shorter-than-average stays that end in a transfer and replacement medical device credits	Applied to stays where costs exceed payment beyond a fixed loss threshold
Other Inpatient Hospital	Approach C	Included in claim allowed amount	May be included in claim allowed amount	May be included in claim allowed amount

[6] Acute hospitals include hospitals paid under Medicare's Inpatient Prospective Payment System (IPPS), Maryland hospitals, Critical Access Hospitals (CAHs), children's hospitals, and cancer hospitals. While Maryland hospitals, CAHs, children's hospitals, and cancer hospitals are paid under special systems, they provide a similar set of acute hospital services as IPPS hospitals.

B. Outpatient Facilities

Standardization Approaches A, B, and C are used to calculate the standardized allowed amount for care provided in outpatient facilities. Outpatient care is provided in seven settings: Outpatient Hospitals, Critical Access Hospitals (CAHs), Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), (Community) Outpatient Rehabilitation Facilities (CORF/ORFs), and renal dialysis facilities. Approach A is used for certain services (i.e., reasonable cost or pass-through services) in outpatient hospitals, CAHs, CMHCs, and separately payable services provided in renal dialysis facilities. Approach B is used for all other services in outpatient hospitals, CAHs, CMHCs, CORFs, and ORFs which are paid under the outpatient department, physician, laboratory, ambulance, and DMEPOS fee schedules. Approach C is used for services at RHCs and FQHCs which are paid according to an all-inclusive rate per visit. While Approach A and C have the core cost, add-ons/deductions, and outlier payment components included in the claim allowed amount, Approach B calculates each component according to the following description. Table 2 outlines how standardized allowed costs are calculated for all services in outpatient facilities.

Component 1: Core Cost

In Approach B, the core cost is calculated by multiplying the fiscal year- and service-specific base payment rate and the revenue units reported on the claim. The payment rates are defined by the physician, lab, outpatient department (OPD), DMEPOS, or End Stage Renal Disease (ESRD) fee schedules, depending on the type of service. The following provides a simple example of how the core cost component is calculated under Approach B.

(3)

$$Core\ cost_{outpatient} = service\ specific\ payment\ rate\ x\ revenue\ units$$

Example: Biopsy in Outpatient Hospital (Approach B)

The core cost of a needle biopsy in an outpatient hospital would be calculated using the FY2012 OPD fee schedule rate for a biopsy of $112.83.

(4)

$$Core\ cost_{2,needle\ \ biopsies\ \ in\ OPD,2012} = \$112.83\ x\ 2\ units = \$225.66$$

Component 2: Add-ons or Deductions

When multiple therapies are performed, Approach B reduces the allowed amount for outpatient services provided in outpatient hospitals, CAHs, CMHCs, CORFs and ORFs, and renal dialysis facilities. In addition, Approach B includes the deductions for use of specific devices and clotting factors in calculating the standardized allowed amounts for services in outpatient hospital settings or renal dialysis facilities, respectively.

Component 3: Outlier Payments

When applicable, Approach B includes outlier payments given to cover outpatient services across all settings except renal dialysis facilities that are significantly more expensive than expected. All claim outlier payments are included after removing geographic wage differences.

Table 2. Outpatient Hospital Standardization Components

Outpatient Facility Type	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Outpatient Hospitals, CAHs, and CMHCs[7,8]	Reasonable cost / pass through services: Approach A	Included in claim allowed amount	May be included in claim allowed amount	May be included in claim allowed amount
	Services paid under OPD, lab, physician, ambulance, or DMEPOS fee schedule: Approach B	Fee schedule rate multiplied by units	OPD deductions for device purchase offsets and reduced or discontinued procedure reductions Physician fee schedule deductions for multiple therapies	Applied to care that is significantly more expensive than expected
RHCs and FQHCs	Approach C	Included in claim allowed amount	None	Applied to care that is significantly more expensive than expected
CORFs and ORFs	Approach B	Physician fee schedule rate multiplied by units	Deductions for multiple therapies	Applied to care that is significantly more expensive than expected
Renal dialysis facilities	Dialysis services: Approach B	Calculated based on the ESRD PPS PRICER logic and fee schedule[9]	Add-ons for use of clotting factor	Applied to care that is significantly more expensive than expected
	Separately payable services (pre-2011): Approach A	Included in claim allowed amount	May be included in claim allowed amount	May be included in claim allowed amount

[7] Services delivered in an outpatient setting are payment standardized in the same way for Maryland hospitals and non-Maryland hospitals. Although Maryland hospitals are not paid under the outpatient prospective payment system (OPPS), the payments made for their services are standardized the same way as other hospitals in order to allow for uniform national standardization and to facilitate national resource use comparisons.
[8] Outpatient services can be provided in skilled nursing facility and home health settings. These services are standardized in the same way as all other OPD services.
[9] The ESRD PPS PRICER logic is detailed on this CMS webpage.

C. Carrier (Physician/Supplier Part B) claims

Standardization Approaches A and B are used to calculate the standardized allowed amount for carrier claims (also known as physician/supplier Part B claims (PB)), which are submitted by physicians to CMS for reimbursement of services. Carrier claims are categorized into six services: physician services, anesthesia services, ambulatory surgical centers (ASCs), clinical laboratory services, drugs covered by Part B, and ambulance services. Approach A is used for drugs covered under Part B, automated lab tests, and lab panels which are paid at a national rate. Approach B is used for physician services, anesthesia services, ASCs, ambulance services, and the remainder of lab services. The following describes how the core cost, add-ons or deductions, and applicable outlier payments are calculated for carrier claims under Approach B. Table 3 provides a summary for all physician/supplier services.

Component 1: Core Cost

For physician services, anesthesia services, ASCs, and most lab services, Approach B calculates the core cost component of the standardized allowed amount with the fiscal year- and service-specific payment rate drawn from the physician, ASC, and lab fee schedules and the service count reported on the claim. The following provides a simple example of how the core cost component is calculated under Approach B.

(5)

$$Core\ cost_{carrier} = service\ specific\ payment\ rate\ x\ service\ count$$

Example: Electrolyte Panel (Core Cost Approach B)

The core cost of an electrolyte panel is calculated using the FY2012 lab fee schedule rate of $13.43.

(6)

$$Core\ cost_{3,electrolyte\ \ panels\ ,2012} = \$13.43\ x\ 3\ services = \$40.29$$

For ambulance services, a modified version of Approach B calculates the core cost component not accounting for differences in service count (e.g., mileage). Instead, the empirical arithmetic mean of the line allowed amount by ambulance procedure code for each year is used as the service specific payment rate and each line is counted as a single service. This modified approach avoids assigning higher standardized payments to rural providers due to longer ambulance rides.

Component 2: Add-ons or Deductions

When applicable, Approach B includes the setting- and fee schedule-specific add-ons and deductions when calculating the standardized allowed amount.

Component 3: Outlier Payments

Outlier payments are not applicable because Medicare does not make outlier payments for physician services.

Table 3. Carrier (Physician/Supplier Part B) Claims, by Service Type

Service Type	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Physician Services	Approach B	Physician fee schedule rate multiplied by units	Deductions for shared global surgeries, co-surgeries, assistant surgeons, non-physician practitioners, and bilateral, endoscopy, diagnostic imaging, cardiovascular, and multiple therapy procedures	Not applicable
Anesthesia Services	Approach B	Anesthesia base units multiplied by conversion factor	Deductions for physicians overseeing multiple concurrent procedures and procedures performed by non-physicians	Not applicable
Ambulatory Surgical Center (ASC)	Approach B	ASC payment rate multiplied by units	Deductions for multiple surgeries, reduced-price procedures, and procedures discontinued prior to the administration of anesthesia	Not applicable
Clinical Laboratory Services	Auto-test panel services: Approach A	Included in claim allowed amount	None	Not applicable
	All other services: Approach B	Lab fee schedule multiplied by units	None	Not applicable
Drugs Covered by Part B	Approach A	Included in claim allowed amount	None	Not applicable
Ambulance Services	Modified version of Approach B	The average line allowed amount for each ambulance procedure code is calculated each year and assigned as the standardized allowed amount	None	Not applicable

E. Skilled Nursing Facilities

Standardization Approach B and C are used to calculate the standardized allowed amounts for skilled nursing services. Skilled nursing services are provided in skilled nursing facilities (SNF) and swing beds in critical access hospitals (CAHs).[10] Approach B is used for SNF services provided in traditional skilled nursing facilities; Approach C is used for SNF services provided in CAHs. The following outlines how the core cost, add-ons or deductions, and applicable outlier payments are calculated under Approach B. Table 4 summarizes each component for services provided in both SNF and CAHs.

Component 1: Core Cost

Approach B is used for services provided in traditional skilled nursing facilities, and the core cost is calculated at the line level. The payment rate is specific to the line resource utilization group (RUG) and is taken as the average between the urban and rural RUG rates. The applicable units are populated by the revenue units on the claim line. The following provides a simple example of how the core cost component is calculated under Approach B.

(7)

$$Core\ cost_{SNF} = RUG\ specific\ payment\ rate\ x\ revenue\ units$$

Example: Five-day Clinically Complex Care Stay in a SNF (Core Cost Approach B)
The core cost of a five-day clinically complex care stay in 2012 is calculated using the FY2012 RUG average rate of $279.80.

(8)

$$Core\ cost_{5-day\ clinically\ complex\ care,\ 2012} = \$279.80\ x\ 5\ days = \$1{,}399.00$$

Component 2: Add-ons or Deductions

Approach B includes the add-on payment when skilled nursing services in a traditional SNF are provided to a patient who has AIDS.

Component 3: Outlier Payments

Medicare does not make outlier payments for SNF services.

[10] CAH swing beds are beds in small, rural hospitals that can be used to provide SNF care when needed. CAH swing bed claims are paid on a reasonable cost basis rather than according to SNF PPS and therefore do not report the necessary information needed to calculate standardized allowed amounts like services provided in traditional SNFs.

Table 4. Skilled Nursing Services

Setting Type	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Skilled Nursing Facility	Approach B	Average of urban and rural RUG rate multiplied by revenue units	Add-ons for patients with AIDS	Not applicable
CAH swing bed	Approach C	Included in claim allowed amount	None	Not applicable

F. Home Health Agencies

Standardization Approach B is used to calculate standardized allowed amount for all home health services. For services provided by home health agencies (HHA), the standardized allowed amount is calculated differently based on the type of service and level of utilization of services provided. The following provides a general outline of how the core cost, add-ons or deductions, and any applicable outlier payments are calculated for home health services. Home health services are paid by Medicare in units of 60-day episodes. If a Medicare patient is discharged or transferred to another HHA during the 60-day episode, the HHA claim will be adjusted as a partial episode. Furthermore, if a Medicare patient is only visited four or fewer times during a home health episode, a low-utilization payment adjustment (LUPA) will be applied to the HHA claim. Table 5 outlines the differences in each calculation step by episode length and utilization level.

Component 1: Core Cost

For normal or partial-episode length, the core cost component is determined by the annual base rate and the home health resource group (HHRG) weight as shown in the following example.

(9)

$$Core\ cost_{HH} = HH\ base\ rate\ x\ HHRG\ weight$$

Example: Full Length Home Health Episode (Core Cost Approach B)

The core cost for a full-length early episode with 0-13 therapies in FY2012 is calculated using the FY2012 home health base rate of $2,138.52 and the HHRG weight for a full length, early episode with 0-13 therapies of 0.834.

(10)

$$Core\ cost_{early\ \ episode\ \ with\ 0-13\ therapies,2012} = \$2{,}138.52\ x\ \ 0.834 = \$1{,}783.52$$

For home health episodes with four or fewer visits, the core cost component is determined by the type and number of visits as shown in the following example.

Example: Home Health Episode with Fewer than Four Visits

The core cost for two physical therapy visits and one speech therapy visit in 2012 is calculated using the FY2012 home health rates of $123.43 per physical therapy visit and $134.12 per speech therapy visit.

(11)

$$Core\ cost_{HH,LUPA} = \sum_{all\ types} visit\ type\ rate\ x\ \#\ visits\ of\ that\ type$$

(12)

$$Core\ cost_{LUPA,2\ physical\ \ and\ \ 1\ speec\ h\ therapy\ ,2012} = (\$123.43\ x\ \ 2) + (\$134.12\ x\ 1) = \$463.68$$

Component 2: Add-ons or Deductions

Add-ons can be included for use of non-routine supplies (NRSs) and LUPA episodes while deductions are taken for partial episodes.

Component 3: Outlier Payments

Home health services can receive outlier payments to cover care that is significantly more expensive than expected. All claim outlier payments are included after removing geographic wage differences.

Table 5. Home Health Agency Standardization Components

Home Health Service	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Full-Episode	Approach B	Base rate multiplied by HHRG weight	Add-on for NRSs	Applied to care that is significantly more expensive than expected
Partial-Episode	Approach B	Base rate multiplied by HHRG weight	Add-on for NRSs Deduction taken for the shorter length of stay	Applied to care that is significantly more expensive than expected
Low Utilization	Approach B	Sum of payment rates for each individual visit	Add-ons for low utilization payment adjustment (LUPA)	Applied to care that is significantly more expensive than expected

G. Hospice Services

Standardization Approach B is used for all traditional hospice services as well as physician services in the hospice setting. Below is an outline of how the core cost and add-ons or deductions are calculated to get a standardized allowed amount for hospice services. Hospice services are categorized into five types: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC), and services performed by a physician or nurse practitioner. The allowed amount for the first four service types are standardized in the same way while the last type depends on the provider, as outlined in Table 6.

Component 1: Core Cost

Using Approach B, the core cost component for RHC, CHC, IRC, and GIC hospice services is calculated using the fiscal year- and service-specific payment rate and the revenue units reported on the claim. For services that are billed as continuous home care services but with fewer than eight revenue units, the core cost is calculated using the rate for routine home care as shown in the following example.

(13)

$$Core\ cost_{Hospice} = service\ specific\ payment\ rate\ x\ revenue\ units$$

Example: Routine Home Care (Core Cost Approach B)

The core cost of five units of routine home care in 2012 is calculated using the FY2012 payment rate for RHC services of $151.03.

(14)

$$Core\ cost_{5\ units\ of\ RHC,2012} = \$151.03\ x\ 5 = \$755.15$$

For services provided by physicians or nurse practitioners, the core cost is calculated by matching the procedure on each claim line to a payment rate under the physician fee schedule (see how physician services are standardized under the Carrier Claims section above).

Component 2: Add-ons or Deductions

For hospice services provided by a physician or nurse practitioner, the standardized allowed amount includes a 15% deduction.

Component 3: Outlier Payments

Outlier payments are not applicable because Medicare does not make outlier payments for hospice services.

Table 6. Hospice Services Standardization Components

Hospice Services	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
Routine home care, inpatient respite care, general inpatient care, and continuous home care services	Approach B	Hospice service payment rate multiplied by units	None	Not applicable
Physician or nurse practitioner services	Approach B	Physician fee schedule rate multiplied by units	Deduction of 15% for care provided by nurse practitioners	Not applicable

H. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Standardization Approach A and B are used to calculate the standardized allowed amount for durable medical equipment (DME). The types of equipment include general durable medical equipment, oxygen and parenteral and enteral nutrition services, prosthetics, orthotics, and supplies. Approach A is used for oxygen, parenteral and enteral nutrition (PEN) supplies, and maintenance and servicing fees which are paid at a national rate. Approach B is used for general DME and prosthetics, orthotics, and supplies. The following sections summarize how the core cost and add-ons/deductions are calculated for equipment and supplies under Approach B. Table 7 outlines the differences in each standardized allowed amount component, by type of equipment.

Component 1: Core Cost

For general DME and prosthetics, orthotics, and supplies (POS), Approach B calculates the core cost component of the standardized allowed amount with the HCPCS- and modifier-code specific payment rate set in the DMEPOS fee schedule. The following provides a simple example of how the core cost component is calculated under Approach B.

(15)

$$Core\ cost_{DME,POS} = service\ and\ modifier\ specific\ rate\ x\ units$$

Example: Diabetic Testing Lancets (Core Cost Approach B)

The core cost of purchasing ten boxes of diabetic testing lancets by mail in 2012 is calculated using the HCPCS- and modifier-code specific payment rate of $10.80.

(16)

$$Core\ cost_{10\ boxes\ \ lancets\ \ by\ mail\ ,2012} = \$10.80\ x\ 10 = \$108$$

Component 2: Add-ons or Deductions

Approach B includes add-ons for the purchase of a power wheelchair, where the amount is higher for a new wheelchair as opposed to a used wheelchair. There are also deductions applied to equipment rentals compared to purchases.

Component 3: Outlier Payments

Outlier payments are not applicable because Medicare does not make outlier payments for DME, POS, oxygen, or PEN supplies.

Table 7. Durable Medical Equipment Standardization Components

DMEPOS Type	Standardization Approach	Core Costs	Add-ons/Deductions	Outlier Payments
General durable medical equipment and supplies	Approach B	DMEPOS fee schedule national ceiling multiplied by units	Add-ons for wheelchair purchase Deductions for rentals	Not applicable
Oxygen and parenteral and enteral nutrition services	Approach A	Included in the claim allowed amount	None	Not applicable
Maintenance and Servicing	Approach A	Included in the claim allowed amount	None	Not applicable
Prosthetics, orthotics, or therapeutic shoes	Approach B	5/6th the DMEPOS fee schedule national ceiling multiplied by units	None	Not applicable

APPENDIX A: MEDICARE SERVICE TYPES

Table A.1 summarizes each of the seven Medicare service type described in this document: inpatient hospital, outpatient hospital, carrier (physician services), skilled nursing facility (SNF), home health agency, hospice, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Table A.1: Medicare Service Types and Abbreviations

Service Type	Service Type Abbreviation	Medicare FFS Program	Service Type
Inpatient	IP	Part A	Services provided in inpatient hospital facilities
Outpatient	OP	Part B	Services provided in outpatient hospital facilities
Carrier (or Physician/Supplier Part B claims)	PB	Part B	Services provided by non-institutional physician/suppliers
Skilled Nursing	SNF	Part A	Rehabilitation and skilled nursing services
Home Health	HH	Part A and B	Services administered in beneficiaries' home; may include therapy and social services
Hospice	HS	Part A	Hospice services include physician services, nursing visits, medical social services, and counseling
Durable Medical Equipment	DME	Part B	Durable medical equipment, such as wheelchairs and oxygen tanks