Outlier claim information and submission instructions

To qualify as an outlier, the claim must have costs above a fixed loss threshold amount. The CMS publishes the amount in the annual Inpatient Prospective Payment System (IPPS) Final Rule.

Cost outliers apply to all inpatient facilities including, but not limited to:

* Acute Care Facilities,
* Inpatient Rehab Facilities,
* Inpatient Psychiatric Facilities,
* Long Term Care Facilities, and
* Veterans Affairs claims for the eMRA project

To bill an outlier, there must be days of utilization (Medicare benefit days) available to the beneficiary. To properly code an outlier claim, the provider must know the Covered, Non-covered, Co-insurance, and Lifetime Reserve Days (LTR) available. It is only after all days have been used that benefits are exhausted.

Two pieces of information are needed to determine if an outlier should be coded:

1. Total covered charges
2. IPPS threshold amount

When total covered charges exceed the threshold, follow the coding rules for an outlier claim.

Outlier coding rules and guidelines

* Outlier payments are made for each day during the outlier period that the beneficiary has available benefit days (regular, co-insurance, or LTR).
* When there are enough full and/or coinsurance days to cover all the medically necessary days, or the only available benefits are LTR, and there are enough to cover all the medically necessary days, do not report Occurrence Code (OC) 47.
* When full and/or coinsurance days and LTR days are billed on the same claim, LTR days begin on the outlier date (OC 47) or after any remaining coinsurance days are exhausted (OC A3).
* Diagnosis Related Group (DRG) claims without cost outlier payments (no OC 47 reported on the claim) can never have regular benefits days combined with LTR benefit days.
* Exclude days and covered charges during non-covered spans (e.g., leave of absence or patient liability).

Outlier related definitions

* Cost outlier threshold: The dollar amount that a claim has to exceed to be eligible to receive an outlier payment
* Benefit period: Time period defining a Medicare Beneficiary's inpatient benefits
* May include 60 full hospital days, 30 coinsurance days and 60 LTR days.
* Condition code (CC) 61: Cost outlier. Providers do not report this code. Indicates the bill is paid as an outlier.
* CC 67: Report this code to indicate the beneficiary has elected not to use LTR days.
* CC 68: Report this code to indicate the beneficiary has elected to use LTR days.
* OC 47: Date cost outlier status begins. This code is not reported when there are enough full and/or coinsurance days to cover all the medically necessary days, or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. The associated date is the date after the day covered charges reach the threshold. This date cannot be equal to or during the dates coded for occurrence span codes (OSC) 74, 76, or M1.
* OC A3: Benefits have exhausted. Report the last date for which benefits are available.
* Occurrence span code (OSC) 70/Inlier: Providers do not report this OSC code for outlier claims. The OSC 70 is applied during processing and represents from and through dates for which the beneficiary exhausted all regular days and/or co-insurance days. These are days that fall within the DRG payment. This is known as the inlier portion of a claim.
* OSC 74: From and through dates for a period of non-covered level of care in an otherwise covered stay. This code is used for leave of absence or repetitive Part B services to show a period of inpatient care or outpatient surgery during the billing period.
* OSC 76: From and through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary (beneficiary liable).
* OSC M1: Provides the from/through dates of a period of non-covered care. For providers to indicate provider is fully liable and the benefit days are not to be applied, providers must include remarks.
* Value code (VC) 17: Outlier payment. Providers do not report this code. Indicates the amount of the cost outlier payment.

Coding the claim

Step 1

Determine the IPPS threshold and determine if days are available.

* Determine the days available by verifying eligibility in our Novitasphere Portal.
* The dollar amount of the cost outlier threshold can be determined in one of two ways:
* Download the CMS [PC PRICER](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index.html?redirect=/PCPricer/) and calculate the amount based on data from the claim.
* Use the cost outlier threshold amount shown in the Outlier Amt field on page six of the Direct Data Entry (DDE) claim after the claim has been submitted.

Step 2

Compare total covered charges against the IPPS threshold amount.

Step 3

After the cost outlier threshold is known, providers must do the following:

* Add the daily covered charges for the claim until you determine the day that covered charges reach the cost outlier threshold; exclude days and covered charges during non-covered spans, i.e., during OSC 74, 76, or M1 dates.
* Submit the date of the first full day of outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47.
* Any non-utilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be coded by the Fiscal Intermediary Shared System using OSC 70.
* LTR days should be used as necessary and as elected by the beneficiary.
* If coinsurance days exhaust during the inlier portion of the stay and there is a period of non-utilization indicated by the presence of OSC 70, and the beneficiary elects not to use LTR days, covered charges are limited up to or equal to the amount of the cost outlier threshold and both OC A3, (last covered day) and OC 47 (first full day of cost outlier status).
* When using all coinsurance and/or LTR days during the cost outlier portion of the stay, report OC A3 with the date benefits exhausted.
* Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted.

Charges cannot exceed the cost threshold. As a result, there may be ancillary charges that need reported as non-covered so that the total covered charges are at or below the cost threshold.

Interactive Cost Outlier Tool

Novitas has developed an [Interactive Cost Outlier Tool](https://www.novitas-solutions.com/SupportFiles/webFiles/NovExternal/video/CostOutlier/index.html) to assist you in determining the proper billing of your IPPS outlier claims. The tool is to be used to advise on billing scenarios and is not to be used in determining whether an outlier payment will be received.

If you have trouble viewing the tool, [read the text transcript](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00273709).

Outlier claim examples

Assumptions for all the following examples

1. Cost outlier threshold amount is $50,000

2. Threshold amount is reached on the 25th day

1. Billed charges are $1,000 each day thereafter
2. Beneficiary elects to use any available LTR days

Example 1

LTR days cover cost outlier (benefits cover stay)

* Dates of service: 1/1/15 - 1/31/15 discharge
* Medically necessary days: 30
* Covered charges: $55,000
* Benefits available: 30 LTR
* Covered days: 30
* Non-covered days: 0
* Cost report Days: 30
* All charges for Medicare approved revenue codes billed as covered
* No OC 47 needed
* Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 2

LTR days exhaust in the cost outlier (benefits exhaust after the OC 47 date)

* Dates of service: 1/1/15 - 2/10/15 discharge
* Medically necessary days: 40
* Covered charges: $65,000
* Benefits available: 30 LTR
* Covered days: 30
* Non-covered days: 10
* Cost report Days: 30
* 30 days covered charges for Medicare approved revenue codes and 10 days non-covered charges
* OC 47: 1/26/15
* OC A3: 1/30/15
* Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier)

Example 3

LTR days exhaust prior to cost outlier (benefits exhaust prior to the OC 47 date)

* Dates of service: 1/1/15 - 1/31/15 discharge
* Medically necessary days: 30
* Covered charges: $55,000
* Benefits available: 20 LTR
* Covered days: 20
* Non-covered days: 10
* Cost report Days: 25
* 25 days covered charges for Medicare approved revenue codes and 5 days non-covered charges
* OC 47: 1/26/15
* OC A3: 1/25/15
* OSC 70: 1/21/15-1/25/15
* Reimbursement: Full DRG payment, no cost outlier

Example 4

Coinsurance days exhaust prior to cost outlier and no LTR days are available (benefits exhaust prior to the OC 47 date)

* Dates of service: 1/1/15 - 1/31/15 discharge
* Medically necessary days: 30
* Covered charges: $55,000
* Benefits available: 20 coinsurance
* Covered days: 20
* Non-covered days: 10
* Cost report Days: 25
* 25 days covered charges for Medicare approved revenue codes and 5 days non-covered charges
* OC 47: 1/26/15
* OC A3: 1/25/15
* OSC 70: 1/21/15-1/25/15
* Reimbursement: Full DRG payment, no cost outlier

Example 5

Coinsurance days exhaust prior to cost outlier. LTR days exhaust in the cost outlier (benefits exhaust after the OC 47 date)

* Dates of service: 1/1/15 - 2/10/15 discharge
* Medically necessary days: 40
* Covered charges: $65,000
* Benefits available: 20 coinsurance and 10 LTR
* Covered days: 30
* Non-covered days: 10
* Cost report Days: 35
* 35 days covered charges for Medicare approved revenue codes and 5 days non-covered charges
* OC 47: 1/26/15
* OC A3: 2/4/15
* OSC 70: 1/21/15-1/25/15
* Reimbursement: Full DRG payment plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 non-covered)

Example 6

Full and coinsurance days cover cost outlier (benefit days cover stay)

* Dates of service: 1/1/15 - 1/31/15 discharge
* Medically necessary days: 30
* Covered charges: $55,000
* Benefits available: 10 full and 20 coinsurance
* Covered days: 30
* Non-covered days: 0
* Cost report Days: 30
* All charges for Medicare approved revenue codes billed as covered
* No OC 47 needed
* Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 7

Coinsurance days and LTR days exhaust in the cost outlier (benefits exhaust after the OC 47 date)

* Dates of service: 1/1/15 - 2/28/15 discharge
* Medically necessary days: 58
* Covered charges: $83,000
* Benefits available: 10 full, 30 coinsurance and 10 LTR
* Covered days: 50
* Non-covered days: 8
* Cost report Days: 50
* 50 days covered charges for Medicare approved revenue codes and 8 days non-covered charges
* OC 47: 1/26/15
* OC A3: 2/19/15
* Reimbursement: Full DRG plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 non-covered)

Example 8

LTR days exhaust prior to cost outlier and non-covered span(s) present (benefits exhaust prior to the OC 47 date)

* Dates of service: 1/1/15 - 1/31/15 discharge
* Medically necessary days: 28
* OSC 76: 1/10/15 - 1/11/15
* Covered charges: $55,000
* Benefits available: 20 LTR
* Covered days: 20
* Non-covered days: 10
* Cost report Days: 25
* 25 days covered charges for Medicare approved revenue codes and 5 days non-covered charges
* OC 47: 1/28/15
* OC A3: 1/27/15
* OSC 70: 1/23/15-1/27/15
* Reimbursement: Full DRG payment, no cost outlier.

Common return reasons for outlier claim scenarios

37025

Description of problem: Accommodation units are not present on page 3.

Resolution: Accommodation units are required; add the appropriate accommodation revenue code and units.

37035

Description of problem: The OC 47 and OC A3 are billed on the same date.

Resolution: The benefits exhaust code, A3, should be reported the date prior to the OC 47 if benefit days exhausted prior to the OC 47. The A3 should only be reported after the OC 47 if the benefits exhaust after the inlier days.

Or

Description of problem: The OC A3 is billed, and no OC 47 is on claim.

Resolution: Determine when the cost outlier threshold was met, report the appropriate information with OC 47 and if necessary, update OC A3 billing.

37036

Description of problem: Claims must have the dollar amount of the cost outlier threshold reported with OC 47.

Resolution: Determine the appropriate dollar amount and report with the OC 47.

37037

Description of problem: Non-covered days are reported either with no OC or OSC and/or the non-covered days do not match the OC or OSC reported.

Resolution: Determine the number of covered days and verify that the appropriate OC or OSC is reported with the correct number of days.

37045

Description of problem: There are LTR days reported with regular/coinsurance days and no OC 47 is present when a cost outlier scenario exists.

Resolution: When full, co-insurance and LTR are all available and utilized on the same claim, the full and/or coinsurance days can only be reported for the inlier portion of the claim, prior to the OC 47. The LTR days would only be used after the OC 47.

37048

Description of problem: Covered charges are over the cost threshold.

Resolution: Verify covered ancillary charges and adjust as necessary so the claim is at or below the cost threshold.

References

* CMS IOM [Pub.100-04, Claims Processing Manual, Chapter 3, sections 20.1.2, 20.7.4 & 40.2.2](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf)
* [Special Edition Article, SE1310 - Claims Processing Instructions for Inlier Bills and Cost Outlier Bills with Benefits Exhausted](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE1310.pdf#page=3)