Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

NEWS FLASH	Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu, and encourage them to get their flu shot. And don't forget, health care professionals need to protect themselves also. Get Your Flu Shot. – Protect yourself, your patients, and your family and friends. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of adult immunizations and educational resources, go to http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website.

MLN Matters Number: MM5276 | Related Change Request (CR) #:5276

Related CR Release Date: September 25, 2006 | Effective Date: October 1, 2006

Related CR Transmittal #: R1067CP | Implementation Date: October 2, 2006

Note: This article was updated on November 6, 2012, to reflect current Web addresses. All other information remains unchanged.

Fiscal Year (FY) 2007 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH), and Inpatient Psychiatric Facility (IPF) PPS Changes

Provider Types Affected

Hospitals billing Medicare Fiscal Intermediaries (FIs), including Part A/B Medicare Administrative Contractors (A/B MACs), for services paid under the Inpatient Prospective Payment System (IPPS), the Long Term Care Hospital (LTCH), or Inpatient Psychiatric Facility (IPF) PPS.

Provider Action Needed

STOP – Impact to You

This article includes information from Change Request (CR) 5276 that announces changes to the FY 2007 IPPS, LTCH & IPF PPS based on the FY 2007 IPPS Final Rule.

CAUTION – What You Need to Know

This article outlines FY 2007 IPPS changes for hospitals, which were published in the Federal Register on August 18, 2006 and announced in a notice that will be

published on the CMS website. It also addresses new GROUPER and Diagnosis Related Group (DRG) changes that are effective October 1, 2006, for hospitals paid under the LTCH PPS and ICD-9-CM changes that affect the comorbidity adjustment under the IPF PPS.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) published the FY 2007 IPPS Final Rule in the August 18, 2006, Federal Register (http://www.access.gpo.gov/su_docs/fedreg/a060818c.html), and Change Request (CR) 5276 outlines the changes to the FY 2006 IPPS.

CR5276 also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2006 for hospitals paid under the IPPS, as well as under LTCH PPS. LTCH PPS rate changes occurred on July 1, 2006. Please refer to Transmittal 981, CR 5202 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R981CP.pdf), published on June 15, 2006, for LTCH policy changes. The MLN Matters article corresponding to CR 5202 can be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5202.pdf on the CMS website. All items covered in CR 5276 are effective for hospital discharges occurring on or after October 1, 2006, unless otherwise noted.

You may also wish to review the IPF update issued in July, 2006. The MLN Matters article, MM5129, relates to that update and it is available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5129.pdf on the CMS site.

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2006. The new ICD-9-CM codes are listed, along with their DRG classifications, in Tables 6A and 6B of the August 18, 2006, Federal Register (http://www.access.gpo.gov/su_docs/fedreg/a060818c.html). The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6C and 6D. The revised code titles are in Tables 6E and 6F.

GROUPER V24.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2006. The

Medicare Code Editor (MCE) 23.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2006.

1. IPPS Rates for FY 2007 are as follows:

Standardized Amount Update Factor	1.034 1.014 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.034 1.014 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$24,485.00
Federal Capital Rate	$427.03
Puerto Rico Capital Rate	$203.03
Outlier Offset-Operating National	0.948968
Outlier Offset-Operating Puerto Rico	0.967303
Outlier Offset-Operating National PR blend	0.953551
IME Formula	1.32*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor	0.997395

Operating Rates:
RATES with Wage Index Greater than 1 & Full Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3397.52	1476.97
Puerto Rico (PR)	1436.12	880.20
Natl/PR (NPR)	3397.52	1476.97

RATES with Wage Index Less than 1 & Full Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3022.18	1852.31
Puerto Rico (PR)	1359.68	956.64
Natl/PR (NPR)	3022.18	1852.31

RATES with Wage Index Greater than 1 & Reduced Market Basket

	Labor Share	Non-Labor Share
National (NTL)	3331.80	1448.40
Puerto Rico (PR)	1408.34	863.18
Natl/PR (NPR)	3331.80	1448.40

RATES with Wage Index Less than 1 & Reduced Market Basket

	Labor Share	Non-Labor Share
National (NTL)	2963.73	1816.48
Puerto Rico (PR)	1333.38	938.14
Natl/PR (NPR)	2963.73	1816.48

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4A (urban areas), 4B (rural areas) and 4C (redesignated hospitals) of the August 18, 2006, Federal Register (http://www.access.gpo.gov/su_docs/fedreg/a060818c.html).

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy which paid as transfers all cases which assigned to one of 10 DRGs if the patient was discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a long term care hospital, a children's hospital, a cancer hospital, a skilled nursing facility, or a home health agency. As of October 1, 2004, that list was expanded to 29 DRGs. As of October 1, 2005, the list was again expanded.

Effective October 1, 2006, the following DRGs are added to the post acute care transfer list: 398, 399, 562, 563, 565, 566, 567, 568, 569, 570, 572, 573, 575, 576, 578, and 579.

The following DRGs are deleted from the post acute care transfer list: 20, 24, 25, 148, 154, 415, 416, and 475.

3. New Technology Add-On Payment

Effective for discharges on or after October 1, 2006, there is one "new" new technology add-on payment, X STOP Interspinous Process Decompression System, in addition to GORE TAG and Restore Rechargeable Implantable Neurostimulator, which were effective October 1, 2005. Kinetra ® is no longer included. Under 42 CRF 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education, disproportionate share, transfers, etc., but excluding outlier payments.) (CR5276 contains an explanation of how the Pricer calculates total covered costs for this purpose. CR5276 is located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1067CP.pdf on the CMS website.)

In order to pay the add-on technology payment for the Restore Rechargeable Implantable Neurostimulator, Pricer will look for the presence of ICD-9-CM procedure code, 86.98. The maximum add-on payment for the neurostimulator is $9,320.00.

In order to pay the add-on technology payment for GORE TAG, Pricer will look for the presence of ICD-9-CM procedure code 39.73. The maximum add-on payment for GORE TAG is $10,599.00.

In order to pay the add-on technology payment for X STOP, Pricer will look for the presence of ICD-9-CM procedure code 84.58. The maximum add-on payment is $4,400.00.

It is possible to have multiple new technologies on the same claim. Should multiple new technologies be present, Pricer will calculate each separately and then total the new technology payments. The total is in the field labeled "PPS-New-Tech-Payment-Add-On" returned from Pricer.

4. Medicare Dependent Hospital (MDH) Changes

Non Rural Referral Center (RRC) MDHs (Provider Type 14) are relieved of the 12% cap on DSH payments. Previously, only RRC MDHs (Provider Type 15) were relieved of the 12% cap on DSH payments.

Additionally, MDHs have the option to rebase their hospital specific rates to their FY 2002 cost report (cost reports beginning on or after October 1, 2002, and on or before September 30, 2003) if this FY 2002 hospital specific rate results in a payment increase. CR5276 contains details on how your FI or A/B MAC handles this issue.

MDHs will also receive a 75% differential add-on to the federal payment for FY 07. Currently, MDHs receive 50% of the difference between their HSP rate and the federal rate (assuming the HSP rate exceeds the federal rate).

Other Changes

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

In the FY 2007 IPPS final rule, CMS revised the capital PPS large-urban add-on and DSH adjustment regulations at §§412.316(b) and 412.320(a)(1), respectively, to clarify that, beginning in FY 2007, hospitals reclassified as rural under §412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment since these hospitals are considered rural under the capital PPS. CMS also made a technical change in the regulations at §412.316(a) to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. In the case of hospitals reclassified as rural under §412.103, the GAF is determined from the applicable statewide rural wage index.

Reclassification (For IPPS Only)

For FY 2006, FY 2007, or FY 2008, for a campus of a multicampus hospital that wishes to seek reclassification to a geographic wage area where another campus(es) is located, CMS will allow the campus of a multicampus hospital to use the average hourly wage data submitted on the cost report for the entire multicampus hospital as its wage data under 412.230(d)(2). The deadline for multicampus hospitals to reclassify is the same as all other hospitals; that is, they must submit their application to the Medicare Geographical Classification Review Board (MGCRB) by September 1st of each year.

LTCH Changes

LTCH PPS Cost-To-Charge Ratios (CCR)

In the FY 2007 IPPS final rule, CMS revised the methodology for determining the annual LTCH PPS CCR ceiling and statewide average CCRs. Under this revised methodology, CMS now computes a single "total" LTCH CCR ceiling and

applicable statewide average LTCH CCRs using IPPS data rather than adding the separate IPPS operating and capital CCR ceilings or statewide average CCRs as was done previously. For FY 2007, the LTCH PPS total CCR ceiling is 1.321, and the applicable LTCH PPS statewide average CCRs are presented in Table 8C of the Addendum of the FY 2007 IPPS final rule.

LTCH Pricer, DRGs, and Relative Weights

The annual update of the long term care diagnosis-related groups (LTC-DRGs), relative weights and GROUPER software for FY 2007 are published in the annual IPPS final rule. The same GROUPER software developed for the Hospital Inpatient PPS will be used for the LTCH PPS.

The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2006, can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

F. Inpatient Psychiatric Facility Changes

Comorbidity Adjustment

Based on the changes to the ICD-9-CM codes effective October 1, 2006, the following changes are being made to the comorbidity codes in the IPF PPS.

Invalid

Invalid ICD-9-CM Code	Title
238.7	Other lymphatic and hematopoietic tissues (Oncology Treatment)

New

New ICD-9-CM Code	Descriptor
052.2	Postvaricella myelitis (Infectious Diseases)
053.14	Herpes zoster myelitis (Infectious Diseases)
238.71	Essential thrombocythemia (Oncology Treatment)
238.72	Low grade myelodysplastic syndrome lesions (Oncology Treatment)
238.74	Myelodysplastic syndrome with 5 q deletion (Oncology Treatment)
238.76	Myelofibrosis with myeloid metaplasia (Oncology Treatment)
238.75	Myelodysplastic syndrome, unpsecified (Oncology Treatment)
238.79	Other lymphatic and hematopoietic tissues (Oncology Treatment)

Revised (title changes):

ICD-9-CM Code	Descriptor
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease

TEFRA Update

The final excluded hospital market basket increase for FY 2007 is 3.4%.

Additional Information

For complete details, please see the official instruction issued to your intermediary or A/B MAC regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1067CP.pdf on the CMS website.

If you have any questions, please contact your intermediary or A/B MAC at their toll-free number, which may be found on the CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.