



Provider Inquiry Assistance

Fiscal Year (FY) 2009 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes – JA6189

Related CR Release Date : October 3, 2008

Date Job Aid Revised: October 15, 2008

Effective Date: Discharges on or after October 1, 2008

Implementation Date: October 6, 2008

Key Words	MM6189, CR6189, R1610CP, IPPS, LTCH, IPF, PPS, Prospective, Psychiatric
Contractors Affected	<ul style="list-style-type: none"> • Fiscal Intermediaries (FIs) • Medicare Administrative Contractors (A/B MACs)
Provider Types Affected	Providers submitting claims to Medicare FIs and/or A/B MACs for services provided to Medicare beneficiaries



- Change Request (CR) 6189 outlines changes for IPPS hospitals for FY 2009.
- The policy changes for FY 2009 appeared in the Federal Register on August 19, 2008, and the final IPPS rates will be available on the Centers for Medicare & Medicaid Services (CMS) website prior to October 1, 2008.
- CR6189 also addresses changes to Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding that affects LTCH PPS, and IPF PPS.
- The LTCH PPS rate changes occurred on July 1, 2008.

ICD-9-CM Changes

Provider Needs to Know...

- The ICD-9-CM coding changes were effective October 1, 2008. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 1, 2008, *Federal Register*.
- The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d.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. The August 1, 2008, Federal Register notice is available at http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf on the CMS website.

Software Updates

- The LTCH Pricer has been updated with the MS-LTC-DRG table and weights.
- A new MS-DRG Grouper software package, Version 26.0, is effective for discharges on or after October 1, 2008. The Grouper 26.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status).
- The Medicare Code Editor, Version 25.0, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2008.
- The IPPS Pricer FY 2008 used for discharges occurring on or after October 1, 2007, through September 30, 2008, incorporates a correction to Puerto-Rico rates. All IPPS Puerto Rico claims with discharges on or after October 1, 2007, through September 30, 2008, will be reprocessed by Medicare using the corrected rates, which are as follows:
 - Wage Index (WI) > 1 = Labor Share (LS) = \$1,471.10 Non Labor Share (NLS) = \$901.64;
 - WI < 1 = LS = \$1,392.80 NLS = \$979.94; and
 - The revised FY 2008 Puerto Rico capital rate is \$202.89.
- An IPPS Pricer FY 2009 will be used for discharges occurring on or after October 1, 2008. The FY 2009 IPPS Pricer package processes bills with discharge dates on or after October 1, 2003.
- The tables that start on page 3 of MLN Matters MM6189 shows the following rates:
 - FY 2009 IPP rates;
 - Operating Rates W/ Full Market Basket (MB) and WI Greater Than 1
 - Rates W/ Full MB and WI Less Than 1
 - Rates W/ Reduced MB and WI Greater Than 1
 - Rates W/ Reduced MB and WI Less Than 1; and
 - Cost of Living Adjustment (COLA) Factors: Alaska and Hawaii Hospitals.

Postacute Transfer Policy

- The DRGs determined in the post-acute care policy have been modified due to changes made to the MS-DRG system. All post acute transfer MS-DRGs for FY 2009 are listed in Table 5 of the IPPS final rule, which is available at http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf on the CMS website.

New Technology Add-on Payment

- Effective for discharges on or after October 1, 2008, the new technology add-on payment for FY 2009 will be triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and

diagnosis code reflecting clinical trial--V70.7 (Examination of participant in clinical trial).

- If the criteria are met, Medicare will make a maximum add-on payment of up to \$53,000 (that is, 50 percent of the estimated operating costs of the device) per case for cases that involve this technology.
- If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 Code of Federal Regulations (CFR) 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of 50 percent of the costs of the new medical service or technology, or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

State Rural Floor Budget Neutrality Adjustment Factors

- The inclusion of the new Pricer table (see attachment C of CR6189), "State Rural Floor Budget Neutrality Adjustment Factors," is due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570).
- The table in Attachment C of CR6189 lists the blended overall rural floor budget neutral factors that are to be applied onto the wage index based on the provider's geographic state location. Attachment C is available at the end of MLN Matters article MM6189.
- The wage table loaded for the FY 2009 Pricer contains wage index values PRIOR to the application of the blended overall rural floor budget neutrality factors. Pricer is applying the budget neutrality factors from Attachment C to the wage index within the Pricer payment logic. The wage index tables printed in the FY 2009 Federal Register Final Rule Notice already have the blended overall rural floor budget neutrality factors applied. To confirm the wage index Pricer uses in calculating payments with the wage index printed in the Federal Register, providers must take the wage index from Pricer and multiply it by the appropriate factor from Attachment C.

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) Indicator Reporting

- The Deficit Reduction Act of 2005 (DRA) requires a payment adjustment in Medicare DRG payment for certain hospital-acquired conditions. CMS has titled the program, "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."
 - **The hospital-acquired conditions:**
 - Are high cost or high volume or both;
 - Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
 - Could reasonably have been prevented through the application of evidence-based guidelines.
 - Section 5001(c) of the DRA required the Secretary of the Department of Health and Human Services to identify by October 1, 2007, at least two conditions (for discharges occurring on or after October 1, 2008) that IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though
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the secondary diagnosis were not present.

- Version 26.0 of the grouper will include logic to determine the appropriate MS-DRG based on the HAC and POA logic. The HACs payment provision applies only to IPPS hospitals. At this time, the following hospitals are exempt from the HAC payment provision:
 - Critical access hospitals,
 - LTCHs,
 - Maryland waiver hospitals,
 - Cancer hospitals,
 - Children's inpatient facilities
 - IRFs, and
 - Psychiatric hospitals.
- The current proposed list of impacted HACs is listed in the table on pages 6 and 7 of MLN Matters article MM6189. For more information on HAC POA, providers should go to <http://www.cms.hhs.gov/HospitalAcqCond/> on the CMS website.

Provider Specific Information

- Tables 8a and 8b of Section VI of the addendum to the PPS final rule contain the FY 2009 statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR).
- The operating CCR ceiling is 1.196 and the capital ceiling is 0.145.

CBSA Designations

- Attachment A of CR6189 shows the IPPS providers that will be receiving a "special" wage index for FY 2009 (i.e., receives an out-commuting adjustment under Section 505 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)).
- For any provider with a special wage index from FY 2008, FIs and A/B MACs will remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in Attachment A.

Low Volume Hospitals

- Medicare FIs and A/B MACs will identify hospitals considered to be "low volume."
 - Hospitals considered low volume will receive a 25% bonus to the operating final payment.
 - To be considered "low volume", the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report.
 - Hospitals should notify their FI or A/B MAC if they believe they are a low volume hospital. The low volume hospital status is re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination.
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Hospital Quality Initiative

- The FIs and A/B MACs will also identify each hospital that meets the criteria for higher payments per MMA quality standards. The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org/pqri> on the Internet.
- This website is expected to be updated in September 2009. Attachment B of CR6189 includes the list of providers that did not meet the criteria for FY 2009 and therefore, will not receive the 2.0% annual payment update for FY 2009.
- If a provider is later determined to have met the criteria after publication of this list, they will be added to the website and FIs and A/B MACs will update their records accordingly.
- FIs and A/B MACs will identify new hospitals to the Quality Improvement Organizations (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

Capital IPPS Adjustment for Indirect Medical Education (IME)

- As established in the FY 2008 IPPS final rule with comment period (72 FR 47401), in accordance with the regulations at §412.322(c), for discharges occurring during FY 2009, the capital IME adjustment factor equals one-half the current adjustment (that is the amount computed under §412.322(b)). This 50 percent reduction in the capital IME adjustment factor is reflected in the Pricer.

Re-basing of Sole Community Hospitals (SCHs)

- Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) provides an option to SCHs that would allow them to rebase their hospital specific rates using data from their FY 2006 cost report (cost reporting periods beginning on or after October 1, 2005, and on or before September 30, 2006) if this results in a payment increase.
- If the FY 2006 cost report data amount is used, it would be effective for the SCH cost reporting periods beginning on or after January 1, 2009.

The Inpatient Psychiatric Facility

- Based on changes to the ICD-9-CM coding system used under the IPPS, changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS.
- The table on page 9 of MLN Matters article MM6189 lists the FY 2009 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2009 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating DRG adjustment.

- For FY 2009, the diagnosis code of 046.1 (Jakob-Creutzfeldt (MS-DRG 056, 057)) is invalid and no longer applicable for the DRG adjustment.
- Since CMS does not plan to update the regression analysis until it analyzes IPF PPS data, the MS-DRG adjustment factors that are shown in the table on page 10 of MLN Matters article MM6189 are effective October 1, 2008, and will continue to be paid for Rate Year 2009.

Comorbidity Adjustment Update

- The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.
- Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.
- The IPF PPS uses the MS-DRGs coding system, in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is using the FY 2009 Grouper, Version 26.0, which is effective for discharges occurring on or after October 1, 2008.
- CR6189 contains three tables that list the FY 2009 new, revised and invalid ICD-9-CM diagnosis codes, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2009 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

Background

- The final rule of August 19, 2008, did not include the implementation of Public Law 110-275, which extended the hospital reclassification provisions of Section 508 and certain special exceptions through September 30, 2009.
- Providers should refer to Transmittal 1547, CR6114, published on July 2, 2008, for LTCH policy changes. An MLN Matters article related to that transmittal is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6114.pdf> on the CMS website.
- The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2008. IPF PPS rate changes occurred on July 1, 2008.

An MLN Matters article relating to Transmittal 1543, CR6077, published on June 27, 2008, for IPF PPS policy changes is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6077.pdf> on the CMS site.

Operational Impact N/A

Reference Materials

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6189.pdf> on the CMS website. Providers can find the current proposed list of impacted HACs is on pages 6 and 7 of MLN Matters article MM6189.

The official instruction (CR6189) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf> on the CMS website.
