



## Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes – JA6634

Related CR Release Date: September 17, 2009

Date Job Aid Revised: September 28, 2009

Effective Date: Discharges on or after  
October 1, 2009

Implementation Date: October 5, 2009

**Key Words** MM6634, CR6634, R1816CP, IPPS, LTCH PPS, IPF

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Fiscal Intermediaries (FIs)

**Provider Types Affected** Providers submitting claims to Medicare FIs and/or A/B MACs for services provided to Medicare beneficiaries



- Change Request (CR) 6634 outlines the FY 2010 changes to the IPPS, LTCH, and IPF PPS.
- CR6634 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 the IPF PPS.
- The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment, effective October 1, 2009.
- The IPF PPS rate changes occurred on July 1, 2009, and are discussed in MLN Matters® article MM6461.

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## Changes to ICD-9-CM Codes

- The ICD-9-CM coding changes are effective October 1, 2009.
- The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 27, 2009, Federal Register, which may be found at [http://www.access.gpo.gov/su\\_docs/fedreg/frcont09.html](http://www.access.gpo.gov/su_docs/fedreg/frcont09.html) on the Internet.
- The ICD-9-CM codes that have been replaced by expanded codes, or other codes, or have been deleted are included in Tables 6c and 6d of the August 27, 2009, Federal Register.
- The revised code titles are in Tables 6e and 6f of the August 27, 2009 Federal Register.
- The GROUPER contractor, 3M-HIS, introduced a new MS-DRG, GROUPER, Version 27.0, software package effective for discharges on or after October 1, 2009.
- The GROUPER 27.0 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 26.0, which is also developed by 3M-HIS, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2009.

## FY 2010 Changes to IPPS

- The FY 2010 IPPS Pricer is for discharges occurring on or after October 1, 2009.
- It includes all pricing files for FY 2005 through FY 2010 needed to process bills with discharge dates on or after October 1, 2004.

### FY 2009 IPPS Rates

- The FY 2009 rates are listed in the table on page 2 in MLN Matters® article MM6634.

### Operating Rates with FULL Market Basket

- The operating rates with FULL market basket are listed in the table on page 2 in MM6634.

### Rates with REDUCED Market Basket

- The rates with REDUCED market basket are listed in the table on page 2 in MM6634.

### Cost-of-Living Adjustment (COLA) Factors: Alaska and Hawaii Hospitals

- The COLA Factors for Alaska and Hawaii hospitals are listed in the table on page 3 in MM6634. **Note: There are no COLA changes for Hawaii in FY 2010.**

### Postacute Transfer Policy

- Providers can see a listing of all Postacute and Special Postacute MS-DRGs in Table 5 in the IPPS final rule, which may be found at <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/list.asp#TopOfPage> on the CMS website.
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Provider Needs to Know...

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### Items Eligible for New-technology Add-on Payments

- **Total Artificial Heart (TAH-t)** – (Effective in FY2009 and through FY 2010)
  - ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial) triggers add-on payment for the TAH-t it. The maximum add-on payment is \$53,000 per case.
- **Spiration IBV** – (Effective for FY 2010)
  - Spiration® IBV® cases eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 163, 164 and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49. The maximum add on payment for the Spiration® IBV® is \$3,437.50 per case.

**Note:** 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 will be paid that is equal to the lesser of 50 percent of the costs of the new medical service/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 FY 2009 IPPS Pricer included a new Pricer table (“State Rural Floor Budget Neutrality Adjustment Factors”) 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).
  - “Specifically, the Centers for Medicare & Medicaid Services (CMS) must make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under Section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) and the imputed floor under Section 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected. Beginning October 1, 2008, such payments will transition from a nationwide adjustment, with a statewide adjustment fully in place by October 1, 2011.”
  - Providers may view the lists the blended overall rural floor budget neutral factors, for FY 2010 that are to be applied onto the wage index (based on the providers’ geographic state location) in the table in Attachment A of CR6634
  - The wage table loaded for the FY 2010 Pricer contains wage index values **PRIOR** to the application of the blended overall rural floor budget neutrality factors.
  - The Pricer software is applying the budget neutrality factors from Attachment A to the wage index within the Pricer payment logic. The wage index tables printed in the FY 2010 Federal Register Final Rule Notice already have the blended overall rural floor budget neutrality factors applied.
  - To confirm the wage index Pricer used 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 A, which has been duplicated
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in the Additional Information section of MM6634.

### Expiration of Section 508 Reclassifications

- Section 508 of the 2003 Medicare Modernization Act (MMA) will expire on October 1, 2009.
- The Provider Specific Files (PSFs) will be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

### Section 505 Hospital (Out-Commuting Adjustment)

- Attachment B of CR6634 shows the IPPS providers that will be receiving a "special" wage index for FY 2010 (i.e., receives an out-commuting adjustment under Section 505 of the MMA).
- For any provider with a Special Wage Index from FY 2009, 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 B.

### Low Volume Hospitals

- Hospitals considered low volume will receive a 25 percent 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.
- Hospitals will notify their FI or A/B MAC if they believe they are a low volume hospital.
- The low volume hospital status should be 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.

### Hospital Quality Initiative

- 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 2010.
  - Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website. Hospitals not receiving the 2.0 percent Reporting Hospital Quality Data for Annual Payment Update annual payment update for FY 2010 are listed in Attachment C of CR6634.
  - For new hospitals, FIs and A/B MACs will provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and 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.
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### Capital IPPS Adjustment for Indirect Medical Education (IME)

- In the FY 2008 IPPS final rule, CMS adopted a policy to phase-out the capital IPPS teaching adjustment.
- For FY 2009, hospitals would receive 50 percent of the IME adjustment provided under the current formula. Section 4301(b) of the American Recovery and Reinvestment Act (ARRA) removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009 (per CR6444 issued on March 27, 2009).
- The capital teaching adjustment is no longer being eliminated for FY 2010.
- Therefore, the full capital IME teaching adjustment is restored for FY 2010 and will be determined under Section 412.322(b).

### Capital PPS Payment for Providers Redesignated Under Section 1886(d)(8)(B) of the Act

- 42 CFR 412.64(b)(II)(D)(3) implements Section 1886(d)(8)(B) of the Act, which redesignates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS.
- Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the federal payment amount for the urban area to which they are redesignated.
- To ensure these "Lugar hospitals" are paid correctly under the capital PPS, FIs and A/B MACs must enter the urban Core Based Statistical Area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF.

**Note:** This may be different from the urban CBSA in the wage index CBSA field on the PSF for "Lugar hospitals" that are reclassified for wage index purposes.) However, if a "Lugar hospital" declines its redesignation as urban in order to retain its rural status, FIs and A/B MACs must enter the rural CBSA (2-digit state code) in the standardized amount CBSA field on the PSF rather than the urban CBSA from the chart to ensure correct payment under the capital PPS.

### Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under Section 412.103 for Purposes of Capital PPS Payments

- Hospitals reclassified as rural under Section 412.103 are not eligible for the capital Disproportionate Share Hospital adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)).
- Similarly, the Geographic Adjustment Factor for hospitals reclassified as rural under Section 412.103 is determined from the applicable statewide rural wage index.

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### Medicare-Dependent Hospitals (MDHs): Budget Neutrality Adjustment Factors for FY 2002-Based Hospital-Specific (HSP) Rate

- Effective FY 2010, CMS is correcting the MDH, FY 2002 HSP rate calculation to include the cumulative budget neutrality adjustment factor for FYs 1993 through 2002 in addition to the budget neutrality adjustment factors for FYs 2003 forward. Section 5003(b) of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) allows MDHs to rebase their HSP rates using data from their FY 2002 cost report if this results in a payment increase.
  - To implement this provision, CMS issued Transmittal 1067 (CR5276 dated September 25, 2006) with instructions to FIs to determine and update the FY 2002 HSP rate for qualifying MDHs.
  - To calculate a MDH's FY 2002 HSP rate and update it to FY 2007, the instructions directed FIs to apply cumulative budget neutrality adjustment factors for FYs 2003 through 2007. The instructions did not include the cumulative budget neutrality adjustment factor to account for changes in the DRGs from FYs 1993 through 2002.
  - To correct for this, FIs and A/B MACs must adjust any FY 2002 HSP rates of MDHs currently in the PSF by applying a factor of **0.982557**, which is calculated as the product of the following budget neutrality adjustment factors from FYs 1993 through 2002: 0.999851 for FY 1993; 0.999003 for FY 1994; 0.998050 for FY 1995; 0.999306 for FY 1996; 0.998703 for FY 1997; 0.997731 for FY 1998; 0.998978 for FY 1999; 0.997808 for FY 2000; 0.997174 for FY 2001; and 0.995821 for FY 2002.
  - The inflation update from FYs 2002 through 2007 and the cumulative budget neutrality adjustment factors for FYs 2003 through 2007 should have already been applied as specified in Transmittal 1067 (CR5276 dated September 25, 2006).
  - Section 1886(d)(5)(G) of the Act provides that the HSP rate for MDHs is based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever of these HSP rates is the highest. After the FY 2002 HSP rates are adjusted as described above, FIs and A/B MACS should verify that the FY 2002 HSP rate is still the highest of the applicable based years (that is, FY 1982, FY 1987, or FY 2002).
  - In those cases where a MDH's FY 2002 HSP rate is no longer higher than its FY 1982 or FY 1987 HSP rate, the applicable HSP rate (FY 1982 or FY 1987) updated to FY 2007 dollars will be entered in to the PSF effective October 1, 2009.
  - For FY 1982 or FY 1987 HSP rates that had previously been updated to FY 2000 dollars (i.e., a MDH's HSP rate prior to the implementation of the rebasing to FY 2002 provided for by Section 5003(b) of the DRA) before entering it in the PSF with an effective date of October 1, 2009, the FY 1982 or FY 1987 HSP will be updated from FY 2000 dollars to FY 2007 dollars by applying an update factor of **1.233973509**, which is computed as the product of the FY 2001 update factor of 1.034, the FY 2001 budget neutrality factor of 0.997174, the FY 2002 update factor of 1.0275, the FY 2002 budget neutrality factor of 0.995821 and the update and inflation factors for FYs 2003 through 2007 listed above.
  - FIs and A/B MACs will adjust the FY 2002 HSP rates of MDHs currently in the PSF and enter that amount in the PSF with an effective date of October 1, 2009. This
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adjustment to the FY 2002 HSP rates of MDHs is not to be applied in determining payments for discharges occurring prior to October 1, 2009.

- For purposes of the settlement of MDH cost reports that include discharges that occurred from October 1, 2006, through September 30, 2009, FIs and A/B MACs will use the originally computed, that is, the FY 2002 HSP rates of MDHs that is currently in the PSF.

## **Rate Year (RY) 2010 Update of The LTCH PPS**

### **RY 2010 LTCH PPS Rates**

- The LTCH PPS rates are listed in the table on page 6 in MM6634.

### **MS-LTC-DRG Update**

- The LTCH PPS Pricer has been updated with the Version 27.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010.

### **COLA Update for LTCH PPS**

- LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The table on page 6 in MM6634 list the updated COLAs implemented as part of the RY 2010 LTCH PPS Final Rule, which are effective for discharges occurring on or after October 1, 2009.

### **Changes to the CBSA-based Labor Market Definition**

- There are several revisions to the CBSA-based labor market definitions used under the LTCH PPS, which are the basis of the wage index adjustment, effective October 1, 2009. The following changes affect the CBSA codes used for the wage index assignment under the LTCH PPS:
    - For any LTCHs currently located in CBSA 42260, the CBSA code on the PSF will need to be changed to 14660 (from 42260) effective October 1, 2009, due to a title change for that CBSA;
    - For any LTCHs currently located in Bollinger County or Cape Girardeau County, Missouri, the CBSA code on the PSF will need to be changed to 16020 (from the rural 2-digit state code 26) effective October 1, 2009, due to the creation of a new urban CBSA;
    - For any LTCHs currently located in Alexander County, Illinois, the CBSA code on the PSF will need to be changed to 16020 (from the rural 2-digit state code 14) effective October 1, 2009, due to the creation of a new urban CBSA;
    - For any LTCHs currently located in Geary County, Pottawatomie County or Riley County, Kansas, the CBSA code on the PSF will need to be changed to 31740 (from the rural 2-digit state code 17) effective October 1, 2009, due to the creation of a new urban CBSA; and
    - For any LTCHs currently located in Blue Earth County or Nicollet County, Minnesota, the CBSA code on the PSF will need to be changed to 31860 (from the rural 2-digit state code 24) effective October 1, 2009, due to the creation of
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a new urban CBSA.

### Changes to LTCH PPS Payment Policy made by ARRA of 2009

- The February 17, 2009, enactment of the ARRA, made changes to two provisions of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act (MMSEA) of 2007:
  - The 3-year moratoria on the establishment of new LTCHs and LTCH satellites and on the increase in beds in existing LTCHs and LTCH satellites; and
  - Revisions to the percentage threshold payment adjustment for LTCHs and LTCH satellites.
- CR6172, issued on December 19, 2008, and CR5955, issued on March 7, 2008, addressed these changes to the MMSEA, which were finalized in the RY 2010 LTCH PPS final rule.
- The ARRA added an additional exception to the moratorium on the increase in beds in existing LTCHs or LTCH satellites, if an existing LTCH that is located in a state that required a Certificate of Need (CON) had obtained a CON for a bed increase that was issued on or after April 1, 2005, and before December 29, 2007.
- The ARRA amended the MMSEA provision, regarding the percentage threshold payment adjustment. (These ARRA changes were implemented in an interim final rule with comment period, which was published, with the RY 2010 LTCH PPS final rule.)
- Specifically, an additional category of LTCH satellites, "grandfathered" satellites (described at 42 CFR §412.22(h)(3)(i)), was added to those LTCH hospitals within hospitals (HwHs) and satellites identified by the MMSEA as "applicable" for the 3-year percentage threshold increase.
- The ARRA also changed the effective date of all of MMSEA changes from the effective date of MMSEA (December 29, 2009) to July 1, 2007, or October 1, 2007, based upon the particular provision.

### FY 2010 Changes to The IPF PPS

#### DRG Adjustment Update

- The IPF PPS has DRG specific adjustments for MS-DRGs.
  - CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter 5 of the ICD-9-CM or the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).
  - Only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments.
  - Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS identified psychiatric DRGs, the IPF will still receive the federal per diem base rate and all other applicable adjustments.
  - The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain
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consistency.

- The updated codes are effective October 1 of each year.
- Although the code set is being updated, note that these are the same adjustment factors in place since implementation.
- Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS.
  - The table on page 7 of MM6634 lists the FY 2010 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 2010 **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 MS-DRG adjustment.
- The table on page 8 of MM6634 lists the FY 2010 **invalid** ICD-9-CM diagnosis code that is no longer applicable for the DRG adjustment.

Since CMS does not plan to update the regression analysis until the IPF PPS data is analyzed, the MS-DRG adjustment factors, shown in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 3, Section 190.5.1 are effective October 1, 2009, and will continue to be paid for RY 2010.

### Comorbidity Adjustment Update

- The IPF PPS has seventeen 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.

### What are Comorbidities

- 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.
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### MS-Severity DRG Coding System

- The IPF PPS utilizes the MS-Severity DRG 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 currently using the FY 2010 GROUPER, Version 27.0, which is effective for discharges occurring on or after October 1, 2009.

### New, Revised and Invalid ICD-9-CM Diagnosis Codes

- The three tables on pages 8 thru 10 of MM6634 and described below list the FY 2010 **new**, **revised**, and **invalid** ICD-9-CM diagnosis codes, which group to one of the seventeen comorbidity categories for which the IPF PPS provides an adjustment.
- These tables are only a listing of FY 2010 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

#### New ICD-9-CM Diagnosis Codes

- The table on page 8 of MM6634 lists the FY 2010 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS.
- The table lists only the FY 2010 **new codes**, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.
- The RY 2010 IPF Pricer will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

#### FY 2010 Revised ICD-9-CM Diagnosis Codes

- The table on page 9 of MM6634 lists the FY 2010 revised ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS.
- The table only lists the FY 2010 **revised codes** and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

#### Invalid ICD-9-CM Codes

- The table on page 10 of MM6634 lists the **invalid** ICD-9-CM codes no longer applicable for the comorbidity adjustment.
- The RY 2010 IPF Pricer will be updated to remove these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

#### Comorbidity Categories

- The seventeen comorbidity categories, for which CMS is providing an adjustment, their respective codes, including the new FY 2010 ICD codes, and their respective adjustment factors, are listed in the table on page 10 of MM6634.

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## **Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical, or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient (related CR6405)**

Effective for Discharges on or after October 1, 2009

- CMS internally generated a request for a national coverage analysis to establish national coverage determinations (NCDs) addressing Medicare coverage of Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient.
- Information regarding these NCDs can be found in Publication (Pub.) 100-03, Chapter 1, Sections 140.6, 140.7, and 140.8, respectively.
- CMS previously issued CR6405 to provide instruction to hospitals on how to bill erroneous surgeries. It explained that for inpatient claims, hospitals are required to submit a no-pay claim (Type of bill (TOB) 110) when the erroneous surgery related to the NCD is reported.
- If there are also covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims. One claim will have the covered services or procedures unrelated to the erroneous surgery and the other claim with the non-covered services/procedures as a no-pay claim.
- CR6405 also instructed hospitals to report surgical error indicators in the Remarks field of the non-covered TOB 110.
- Effective for discharges on or after October 1, 2009, hospitals are not to report the surgical error indicator as was previously instructed. Instead, the non-covered TOB 110 must have one of the following ICD-9- CM diagnosis code reported in diagnosis position 2-9:
  - **E876.5** - Performance of wrong operation (procedure) on correct patient (existing code),
  - **E876.6** - Performance of operation (procedure) on patient not scheduled for surgery, and
  - **E876.7**- Performance of correct operation (procedure) on wrong side/body part.

**Note: The above codes will not be reported in the External Cause of Injury field.**

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### **Background**

- The policy changes for IPF PPS and LTCHs for FY 2010 appeared in the Federal Register on August 27, 2009.
  - CMS is addressing the changes that are effective for hospital discharges occurring on or after October 1, 2009, unless otherwise noted.
  - In addition, CMS is addressing changes to MS-DRGs and ICD-9-CM coding that affects
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the IPF PPS.

- The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment, effective October 1, 2009.
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Reference  
Materials

- The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf> on the CMS website
  - The official instruction (CR6634) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1816CP.pdf> on the CMS website.
  - The IPF PPS rate changes are discussed in MLN Matters® article MM6461 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6461.pdf> on the CMS website.
  - A one-stop resource web page focused on the informational needs and interests of Medicare Fee-for-Service hospitals is available at the Hospital Center at <http://www.cms.hhs.gov/Center/Hospital.asp> on the CMS website.
  - The LTCH PPS Regulations and Notices are available at <http://www.cms.hhs.gov/longtermcarehospitalpps/> on the CMS website.
  - The IPF PPS Regulations and Notices are available at <http://www.cms.hhs.gov/inpatientPsychFacilPPS/> on the CMS website.
  - Providers may also want to review the MLN Matters® articles relating to the CRs mentioned above. These articles are:
    - MM6172 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6172.pdf>;
    - MM6405 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf>;
    - MM6444 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6444.pdf>;
    - MM5955 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5955.pdf>; and
    - MM5276 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5276.pdf> on the CMS website.
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