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MLN Matters Number: MM4046

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Implementation Date: October 3, 2005

Fiscal Year (FY) 2006 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) for services paid under the Inpatient Prospective Payment System (IPPS) or the Long Term Care Hospital (LTCH) PPS.

Provider Action Needed



STOP – Impact to You

This article includes information from Change Request (CR) 4046 that announces changes to the FY 2006 IPPS and the LTCH PPS based on the FY 2006 IPPS Final Rule.



CAUTION – What You Need to Know

This article outlines FY 2006 IPPS changes for hospitals, which were published in the Federal Register on August 12, 2005, and it also addresses new GROUPER and Diagnosis Related Group (DRG) changes that are effective October 1, 2005, for hospitals paid under the LTCH PPS. LTCH PPS rate changes occurred on July 1, 2005.



GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for details regarding this update.

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Background

This article is based on Change Request (CR) 4046, which outlines FY 2006 IPPS changes for hospitals that were published in the Federal Register on August 12, 2005. The August 12, 2005, Federal Register can be found at the following Government Printing Office (GPO) website:

http://www.access.gpo.gov/su_docs/fedreg/a050812c.html.

Note: All items covered in this article are effective for hospital discharges occurring on or after October 1, 2005, unless otherwise noted.

LTCH PPS rate changes occurred on July 1, 2005. Please refer to Transmittal 578, CR3884, published on June 10, 2005 for LTCH policy changes. CR3884 can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R578CP.pdf> on the CMS website. Or, you may wish to review the related MLN Matters article MM3884, which can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3884.pdf> on the CMS website.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Changes

ICD-9-CM coding changes are effective October 1, 2005. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6a (p. 47632) and 6b (p. 47636) of the August 12, 2005, Federal Register (see http://www.access.gpo.gov/su_docs/fedreg/a050812c.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 (p. 47637) and 6d (p. 47638). The revised code titles are in Tables 6e (p. 47638) and 6f (p. 47639).

GROUPER 23.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (i.e., age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2005. Medicare Code Editor (MCE) 22.0 uses the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2005.

Furnished Software Changes

The following software programs were issued for FY2006:

I. IPPS Pricer 06.0

IPPS Pricer 06.0 is for discharges occurring on or after October 1, 2005. This program processes bills with discharge dates on or after October 1, 2001. Rates were published in the August 12, 2005, Federal Register (see http://www.access.gpo.gov/su_docs/fedreg/a050812c.html).

Rates

Standardized Amount Update Factor	1.037 1.033 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.037 1.033 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	\$23,600.00
Federal Capital Rate	\$420.65
Puerto Rico Capital Rate	\$201.93

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Outlier Offset-Operating National	0.948990
Outlier Offset-Operating Puerto Rico	0.974897
Outlier Offset-Operating National PR blend	0.955467
IME Formula	1.37*[1 + resident-to-bed ratio]**.405-1]
MDH/SCH Budget Neutrality Factor *	0.998993

Operating Rates

Rates With Wage Index Greater than 1 and Full Market Basket		
	Labor Share (LS)	Non Labor Share (NLS)
National (NTL)	3297.84	1433.63
Puerto Rico (PR)	1402.46	859.57
National/Puerto Rico (NPR)	3297.84	1433.63
Rates With Wage Index Less than 1 and Full Market Basket		
	LS	NLS
NTL	2933.52	1797.95
PR	1327.81	934.22
NPR	2933.52	1797.95
Rates With Wage Index Greater than 1 and Reduced Market Basket		
	LS	NLS
NTL	3285.12	1428.10
PR	1397.05	856.26
NPR	3285.12	1428.10
Rates With Wage Index Less than 1 and Reduced Market Basket		
	LS	NLS
NTL	2922.20	1791.02
PR	1322.69	930.62
NPR	2922.20	1791.02

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 12, 2005, Federal Register (see http://www.access.gpo.gov/su_docs/fedreg/a050812c.html).

Post Acute Care Transfer Policy

On October 1, 1998, the Centers for Medicare & Medicaid Services (CMS) established a post acute care transfer policy that paid as transfers all cases assigned to one of 10 DRGs if the patient is discharged to:

- A psychiatric hospital or unit (patient status code 65);
- An inpatient rehabilitation hospital or unit (patient status code 62);
- A long term care hospital (patient status code 63);

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- A children’s hospital (patient status code 05);
- A cancer hospital (patient status code 05);
- A SNF (patient status code 03); or
- A home health agency (patient status code 06).

As of October 1, 2004, that list of 10 DRGs was expanded to 29 DRGs; and, effective for discharges on or after October 1, 2005, the list has been expanded again.

Note: Please see Attachment A of CR4046 for the complete and current list of all post acute care transfer DRGs. CR4046 may be found by going to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4046.pdf> on the CMS website.

Thirteen DRGs are eligible for the special payment methodology wherein the payment is equal to 50 percent of the full DRG payment *plus the single per diem day (rather than double the per diem)* for the first day of the stay plus 50 percent of the regular per diem for the remainder of the stay, up to the full amount of the DRG payment. The 13 special payment DRGs are listed in the following table:

DRG	Description
7	Peripheral and Cranial Nerve and Other Nervous System Procedure with complications or co-morbidities
8	Peripheral and Cranial Nerve and Other Nervous System Procedure <i>without</i> complications or co-morbidities
210	Hip and Femur Procedures Except Major Joint (Age >17) with complications or co-morbidities
211	Hip and Femur Procedures Except Major Joint (Age >17) <i>without</i> complications or co-morbidities
233	Other Musculoskeletal System and Connective Tissue or Procedure with complications or co-morbidities
234	Other Musculoskeletal System and Connective Tissue or Procedure <i>without</i> complications or co-morbidities
471	Bilateral or Multiple Major Joint Procedures of the Lower Extremity
497	Spinal Fusion Except Cervical with complications or co-morbidities
498	Spinal Fusion Except Cervical <i>without</i> complications or co-morbidities
544	Major Joint Replacement or Reattachment
545	Revision of Hip or Knee Replacement
549	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI with complications or co-morbidities
550	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI <i>without</i> complications or co-morbidities

Assigning the correct DRG code is important, and assigning the correct patient status code is just as important as any other coding used when filing a claim. Choosing the patient status code correctly avoids claim errors and helps speed up payment for your claim sooner.

A patient status code is a 2-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the end of a billing cycle (the “through” date of a claim). CMS requires patient status codes for:

- Part A Inpatient Claims (Type of Bills (TOBs) - 11X and 12X);

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- Skilled Nursing Claims (TOBs - 18X, 21X, 22X and 23X);
- Outpatient Hospital Services (TOBs - 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and
- All Hospice and Home Health Claims (TOBs - 32X, 33X, 34X, 81X and 82X).

The patient status code belongs in Field 22 on the UB-92 claim form (or its electronic equivalent) in the Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 format for all Part A inpatient, SNF, hospice, Home Health Agency (HHA) and outpatient hospital services. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).

For providers who file claims in the Fiscal Intermediary Shared System (FISS), the patient status code is entered on Claim page 1. It is important to select the correct patient status code, and if two or more patient status codes could apply, then code to the highest level of care known. Omitting the code or submitting a claim with the incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment taken back. Applying the correct code will help ensure that you receive prompt and correct payment.

Patient Status Codes Affected by the Transfer and Post Acute Care Transfer Policy

The following describes these patient status codes and provides details regarding their appropriate use:

Patient Status Code 02 - Discharged/Transferred to a Short-Term General Hospital for Inpatient Care

This patient status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to LTCHs should be coded with Patient Status Code 63.

Patient Status Code 03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Covered Skilled Care

This patient status code should be used only when a patient is discharged or transferred to a Medicare certified skilled nursing bed **and** qualifies for skilled nursing care. This code should be used whether or not the patient has skilled benefit days. (Also, see Code 61 below.)

This code includes transfers to a rehabilitation unit that is located within a SNF.

This code should **not** be used:

- If the patient is at a non-skilled level of care; or
- The patient is admitted to a non-Medicare certified bed.
- For a patient who is discharged to a facility that has both skilled and non-skilled (intermediate) bed and the patient is transferred to a non-skilled bed.
- For a patient who resides at a Medicare certified SNF but does not receive skilled care services.

Patient Status Code 05 - Discharged/Transferred to Another Type of Institution Not Defined Elsewhere in this Code List

Cancer hospitals excluded from the Medicare PPS and children's hospitals are examples of such other types of institutions.

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The National Uniform Billing Committee (NUBC), as well as CMS, has provided additional situations in which patient status code 05 should be used, other than transfers to non-Medicare certified children's hospitals or cancer hospitals. These situations are as follows:

Patient Status Code 05 – NUBC: Discharged/Transferred to a Non-Medicare PPS Children's Hospital or Non-Medicare PPS Cancer Hospital for Inpatient Care

The NUBC has clarified that patient status code 05 should be used when:

- A patient is discharged to a chemical dependency treatment facility that is not part of a hospital;
- A patient is transferred or discharged from a hospital-based Skilled Nursing Unit (SNU) to the acute care hospital under observation status; or
- A patient is discharged from one acute care facility to another acute care facility for an outpatient procedure with the intention that the patient will not be returning to the first acute care facility following the procedure.

Patient Status Code 06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skills Care

This patient status code should be used when a patient is discharged to home, with home health services that will be provided within three days of the patient's discharge. The NUBC has clarified that this would include:

- Follow-up care by visiting nurses;
- Home health care where the patient is also receiving home oxygen; or
- Home health care where the patient is receiving Durable Medical Equipment (DME) services.

Patient Status Code 07 - Left Against Medical Advice or Discontinued Care (This code affects the regular transfer policy if the patient is admitted into another acute care hospital on the same day.)

The important thing to remember about this patient status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who are triaged and leave without being seen by a physician or non-physician practitioner; and
- Patients who move without notice and the HHA is unable to complete the plan of care.

Patient Status Code 62 - Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Distinct Part Units of a Hospital

Inpatient Rehabilitation Facilities (IRFs) (or designated units) are those facilities that meet a specific requirement that 75 percent of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

Patient Status Code 63 - Discharged/Transferred to Long Term Care Hospitals

LTCHs are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you are not sure

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whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient status code.

Patient Status Code 65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

Although this patient status code has been valid since April 1, 2004, the Medicare system has only accepted this code since January 1, 2005. This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g., Veterans Administration Hospitals).

See CR3364, Transmittal 237, dated July 23, 2004, "Implementation of Patient Status Code 65, Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital," at <http://www.cms.hhs.gov/transmittals/Downloads/R237CP.pdf> on the CMS website. A MLN Matters article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3364.pdf> on the CMS website.

New Technology Add-On Payment

This is effective for discharges on or after October 1, 2005. In addition to Kinetra® (which was effective October 1, 2004), there are two "new" new technology add-on payments:

- Restore Rechargeable Implantable Neurostimulator; and
- GORE TAG.

Note: OP-1, InFUSE™, and CRT-D are no longer eligible for the new technology add-on payment.

Under 42 CFR 412.88 (p. 440) 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 (IME), disproportionate share (DSH), transfers, and so on, but excluding outlier payments.) (See Publication 100-4, Chapter 3, Section 160, for specific payment methodology regarding the new technology add-on payment.)

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 **Kinetra®**, Pricer will look for the presence of ICD-9-CM procedure codes 02.93 AND 86.95: the maximum add-on payment for Kinetra® is \$8,285.00.

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.

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II. GROUPER 23.0

For discharges occurring on or after October 1, 2005, Pricer calls the appropriate GROUPER based on discharge date.

III. MCE 22.0

This applies for discharges occurring on or after October 1, 2005. MCE 22.0 replaces earlier versions and contains complete tables driven by date. The MCE selects the proper internal tables based on discharge date.

Other Changes

Disproportionate Share (DSH) Adjustment for Urban to Rural Providers

The Code of Federal Regulations (42 CFR 412.102 (p. 448)) provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than 0.12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the former Metropolitan Statistical Areas (MSA) definitions (effective during Fiscal Year (FY) 2004), but are now considered rural under the Core Based Statistical Areas (CBSA) definition (effective beginning in FY 2005).

Note: You can find all sections of 42 CFR 412 referred to in this article at the following GPO website:
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html.

These providers must receive an adjustment to their operating DSH payment over the two years (FY 2005 and FY 2006). This adjustment has been coded into the Pricer in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals one-third of the difference between the urban and rural operating DSH for FY 2006 (and two-thirds of the difference between the urban and rural operating DSH for FY 2005).

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

The Code of Federal Regulations (42 CFR 412.64(b)(II)(D)(3) (p.425) implements the Social Security Act (Section 1886(d)(8)(B)), which redesignates certain rural counties—commonly referred to as “Lugar 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.

Currently, there are 98 qualifying “Lugar counties” effective for discharges occurring on or after October 1, 2004. (August 11, 2004; 69 FR 49056 – 49059. See http://www.access.gpo.gov/su_docs/fedreg/a040811c.html.)

Under the capital PPS, the standard federal rate is adjusted to reflect the higher costs incurred by hospitals located in large urban areas (large urban add-on at 42 CFR 412.316 (p. 493)), as well as for hospitals in urban areas with at least 100 beds serving low-income patients (capital DSH adjustment at 42 CFR 412.320 (p. 493)).

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In the August 11, 2004, Hospital Inpatient PPS Final Rule (69 FR 49250; see http://www.access.gpo.gov/su_docs/fedreg/a040811c.htm), effective for discharges occurring on or after October 1, 2004, 42 CFR 412.316 (p. 493) and 42 CFR 412.320 (p. 493) specify that capital PPS large urban add-on payments and capital PPS DSH payments, respectively, are based on a hospital's geographic classification specified in 42 CFR 412.64 (p. 425).

Therefore, hospitals located in one of the 98 qualifying "Lugar counties" are considered urban for payment purposes under the capital PPS and are eligible for the capital PPS large-urban add-on and capital PPS DSH payments, if applicable. However, a "Lugar hospital" may decline its redesignation as urban in order to retain its rural status.

You can find 69 FR 48915-49782 (the FY 2005 Final Rule), CMS Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, at the following GPO website: http://www.access.gpo.gov/su_docs/fedreg/a040811c.html

Multi-Campus Hospitals

Payment Issues

Under current Medicare policy, a multi-campus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the CBSA (or metropolitan division, where applicable) in which the campus of the hospital is located.

Reclassification

For FY 2006, FY 2007, or FY 2008, for a campus of a multi-campus hospital that wishes to seek reclassification to a geographic wage area where another campus(es) is located, CMS will allow the campus of a multi-campus hospital to use the average hourly wage data submitted on the cost report for the entire multi-campus hospital as its wage data under 42 CFR 412.230(d)(2) (p. 475).

The deadline for multi-campus hospitals to reclassify is the same as all other hospitals; that is, they must submit their application to the Medicare Geographic Classification Review Board (MGCRB) by September 1 of each year.

Wage Index Corrections

For FY 2006 and subsequent years, classification/reclassification errors made during the proposed rule:

- CMS made a technical error in assigning the hospital to a geographic labor market area;
- The hospital notifies CMS of the technical error using the formal comment process and during the comment period on the proposed rule;
- The error was not corrected in the Final Rule; and
- The hospital again notifies CMS of the geographic assignment error, via written correspondence or e-mail following the publication of the Final Rule, and CMS agrees prior to October 1 that an error was made.

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- The hospital or its representatives provide documentation to the FI that the criteria above have been met.

For FY 2006 and subsequent years, classification/reclassification errors made for the first time during the final rule:

- CMS made a technical error in the final rule in assigning the hospital to a geographic labor market area; and
- The hospital notifies CMS of the error via written correspondence or e-mail, following the publication of the Final Rule, and CMS agrees prior to October 1 that an error was made.
- The hospital or its representatives provide documentation to the FI that the criteria above have been met.

LTCH Changes

LTCH PPS Cost-to-Charge Ratios (CCR)

To ensure that the distribution of outlier payments remains equitable for FY 2006, an LTCH's overall Medicare cost-to-charge ratio is **considered not to be reasonable if the value exceeds** the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds. These are calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. The combined operating and capital upper limit for FY 06 is 1.423.

The appropriate (combined) statewide average cost-to-charge ratios for FY 2006 can be found in Tables 8A and 8B of the IPPS Final Rule (p.47672). You can review the IPPS and FY 2006 Rates Final Rule at the following GPO website: http://www.access.gpo.gov/su_docs/fedreg/a050812c.html.

LTCH Pricer, DRGs, and Relative Weights

The annual update of the LTC-DRGs, relative weights, and GROUPER software for FY 2006 are published in the annual IPPS final rule. The same GROUPER software developed by 3M for the Hospital Inpatient PPS will be used for the LTCH PPS.

Version 23.0 of the Hospital Inpatient PPS GROUPER will be used for FY 2006, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay, and 5/6th of the average length of stay (for short-stay outlier cases) for FY 2006 was determined using the most recent available LTCH claims data (FY 2004).

For those LTCHs paid under the transition blend methodology under 42 CFR 412.533 (p.514), for FY 2006 CMS is using the rebased FY 2002-based excluded hospital market basket to update the reasonable cost-based portion of their payments.

As stated in the August 12, 2005, FY 2006 IPPS final rule, the forecast for FY 2006 for the FY 2002-based excluded hospital market basket is 3.8 percent. 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, 2005, can be found in Table 11 of the final rule (p. 47682). The IPPS and FY2006 Rates Final Rule can be found at the following GPO website: http://www.access.gpo.gov/su_docs/fedreg/a050812c.html.

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Implementation

The implementation date for the related instruction is October 3, 2005.

Additional Information

For complete details regarding CR4046, please see the official instruction issued to your intermediary regarding this change at <http://www.cms.hhs.gov/transmittals/downloads/R692CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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