



News Flash – On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced two complementary final rules to implement the electronic health records (EHR) incentive program under the Health Information Technology for Economic and Clinical Health (HITECH) Act. Announcement of these regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website for this program at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html> on the CMS website.

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Note: This article was updated on December 10, 2012, to reflect current Web addresses. This article was previously revised on October 4, 2010, to reflect changes made to CR 7134 on October 1, 2010. The list of ICD-9-CM codes for Renal Failure, Chronic in the table on page 14 was corrected. Also, "capital" was added to the first sentence in the first full paragraph on page 8 of this article. The CR release date, transmittal number, and the Web address for accessing CR 7134 were revised. All other information remains the same.

Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

Provider Types Affected

This article is for hospitals and facilities submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for inpatient hospital and long term care hospital services provided to Medicare beneficiaries.

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What You Need to Know

This article is based on Change Request (CR) 7134 which provides the Fiscal Year (FY) 2011 update to the Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS. Medicare Claims Processing Manual updates are also made by CR 7134. In addition, CR 7134 addresses the FY 2011 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding.

Background

CR 7134 outlines changes to the IPPS for Acute Care Hospitals and the LTCH PPS for Long Term Care Hospitals (LTCHs) for Fiscal Year (FY) 2011. The policy changes for Fiscal Year (FY) 2011 appeared in the Federal Register on August 16, 2010.

Note: All items covered in CR 7134 are effective for hospital discharges occurring on or after October 1, 2010, unless otherwise noted.

CR 7134 also addresses the FY 2011 update to the MS-DRGs and the ICD-9-CM coding. The coding changes require an update to the IPF PPS comorbidity adjustment, effective October 1, 2010.

Note: The IPF PPS rate changes occurred on July 1, 2010. Refer to CR 6986 (Transmittal 1981, June 4, 2010) for IPF PPS policy changes at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1981CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2010. New ICD-9-CM codes are listed, along with their MS-DRG classifications, in Tables 6a and 6b of the August 16, 2010, Federal Register. (See

http://www.access.gpo.gov/su_docs/fedreg/fircont10.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. The revised code titles are in Tables 6e and 6f.

The IPPS FY 2011 Update

The FY 2011 IPPS Pricer will be provided to Medicare's Fiscal Intermediary Shared System (FISS) for discharges occurring on or after October 1, 2010. It includes all pricing files for FY 2006 through FY 2011 to process bills with discharge dates on or after October 1, 2005.

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FY 2011 IPPS Rates

Standardized Amount Update Factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	\$23,075.00
Federal Capital Rate	\$420.01
Puerto Rico Capital Rate	\$197.66
Outlier Offset-Operating National	0.948999
Outlier Offset-Operating Puerto Rico	0.948079
Indirect Medical Education (IME) Formula (no change for FY10)	$1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$
Medicare Dependent Hospital (MDH)/Sole Community Hospital (SCH) Budget Neutrality Factor	0.996731
MDH/SCH Documentation and Coding Adjustment Factor	0.9718

Operating Rates with FULL Market Basket

	Wage Index > 1 Labor Share	Wage Index ≤ 1 Labor Share
National	\$3,552.91	\$3,201.75
PR National	\$3,552.91	\$3,201.75
PR Specific	\$1,518.14	\$1,515.70

	Wage Index > 1 Non-Labor Share	Wage Index ≤ 1 Non-Labor Share
National	\$1,611.20	\$1,962.36
PR National	\$1,611.20	\$1,926.36
PR Specific	\$926.53	\$928.97

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Operating Rates with REDUCED Market Basket

	Wage Index > 1 Labor Share	Wage Index ≤ Labor Share
National	\$3,483.49	\$3,139.19
PR National	\$3,552.91	\$3,201.75
PR Specific	\$1,518.14	\$1,515.70

	Wage Index > 1 Labor Share	Wage Index ≤ Labor Share
National	\$1,579.72	\$1,924.02
PR National	\$1,611.20	\$1,962.36
PR Specific	\$926.53	\$928.97

Postacute Transfer Policy

A listing of all Postacute and Special Postacute MS-DRGs (Table 5 of the IPPS Final Rule) is available at <http://www.cms.gov/AcuteInpatientPPS/IPPS2011/itemdetail.asp?filterType=none&filterByDI D=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237948&intNumPerPage=10> on the CMS website.

Acute Care Transfer Policy Changes

The current acute care transfer policy only applies to transfers between acute care hospitals that participate in the Medicare program (“participating acute care hospitals”); it does not currently apply to acute care hospitals that would otherwise be eligible to be paid under the IPPS, but do not have an agreement to participate in the Medicare program (“nonparticipating acute care hospitals”). It also does not currently apply to transfers from IPPS acute care hospitals to Critical Access Hospitals (CAHs).

Effective for discharges on or after October 1, 2010, IPPS hospitals that transfer patients to a non-participating acute-care hospital or a CAH would be subject to the transfer policy. Note that the system changes needed to accommodate this change (transfers to CAHs) will occur in April 2011.

New Technology Add-On Payments

The following items are eligible for new-technology add-on payments in FY 2011:

- **Total Artificial Heart (TAH-t)** – Effective for FY 2009 through FY 2011, the new technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement

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system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial). The maximum add-on payment is \$53,000 per case.

- **Spiration IBV** – Effective for FY 2010 and FY 2011, revised for FY 2011. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment (the maximum add on payment for the Spiration® IBV® is \$3,437.50 per case) 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; or
 - Assignment to MS-DRGs 199, 200, and 201 with procedure code 33.71 or 33.73 in combination with diagnosis code 512.1.
- **AutoLITT**- Effective for FY 2011. Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with one of the following primary diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, or 191.9. The maximum add-on payment for a case involving the AutoLITT™ is \$5,300.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 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.

National Rural Floor Budget Neutrality (RFBN) Adjustment Factors

The wage index table loaded for the FY 2011 Pricer contains wage index values **ALREADY ADJUSTED BY** the national rural floor budget neutrality factor of 0.996641. The statewide rural floor budget neutrality factors in place in FY 2009 and FY 2010 are not effective for FY 2011 per the Affordable Care Act which established the rural floor budget neutrality adjustment as a national factor. To confirm the wage index Pricer uses in calculating payments with the wage index printed in the Federal Register, take the wage index from Pricer and compare it to the wage index value shown in Table 4A, 4B or 4C as appropriate.

Cost of Living Adjustment (COLA) Update for IPPS PPS

IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

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Expiration of Section 508 Reclassifications

The Medicare Modernization Act of 2003 (Section 508) as extended by the Affordable Care Act (visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet) will expire on September 30, 2010.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A of CR 7134 shows the IPPS providers that will be receiving a "special" wage index for FY 2011 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs)

For FY 2011, the hospital-specific (HSP) rates for SCHs and MDHs in the PSF will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2011 is 1.0235 (or 1.0035 for hospitals that do not submit quality data) and the budget neutrality factor is 0.996731. Beginning in FY 2011, a documentation and coding adjustment factor of 0.9718 will also be applied to the HSP rates.

Low Volume Hospitals

The Affordable Care Act (Sections 3125 and 10314) provides for a temporary increase in the low volume adjustment for FYs 2011 & 2012. Specifically, for FY 2011 & FY 2012 a hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has fewer than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year. The Affordable Care Act (Sections 3125 and 10314) also revised the payment adjustment (the applicable percentage increase) for FYs 2011 and 2012. In the FY 2011 IPPS/LTCH PPS final rule, CMS established at 412.101(c)(2) that the low-volume adjustment for FYs 2011 & 2012 will be determined as follows:

- Low-volume hospitals with 200 or fewer Medicare discharges will receive a low-volume adjustment of an additional 25 percent for each discharge.
- Low-volume hospitals with Medicare discharges of more than 200 and fewer than 1,600 will receive for each discharge a low-volume adjustment of an additional percent calculated using the formula: $[(4/14) - (\text{Medicare discharges}/5600)]$.

As established in that same final rule, for FY 2011, the low-volume payment adjustment will be determined using Medicare discharge data for FY 2009 from the March 2010 update of the MedPAR files. CMS provided a chart listing the hospitals with fewer than 1,600 Medicare discharges based on the March 2010

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update of the FY 2009 MedPAR files. However, this list of hospitals with fewer than 1,600 Medicare discharges does not reflect whether or not the hospital meets the mileage criterion, that is, the hospital also must be located more than 15 road miles from any other IPPS hospital. **In order to receive the applicable low-volume percentage add-on payment for FY 2011, a hospital must meet both the discharge and mileage criteria.**

For FY 2011, the hospital should have made its request for low-volume hospital status in writing to its FI or MAC by September 1, 2010, so that the applicable low-volume percentage add-on will be applied to payments for its discharges beginning on or after October 1, 2010, and should have provided documentation that it meets the mileage criterion. FIs/MACs will verify that the hospital meets the discharge criteria by using the table of Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files from the FY 2011 IPPS/LTCH PPS final rule or the table posted on the CMS website at

<http://www.cms.gov/AcuteInpatientPPS/PPS2011/itemdetail.asp?filterType=none&filterByDI D=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237932&intNumPerPage=10> on the CMS website.

For requests for low-volume hospital status received after September 1, 2010, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the applicable low-volume adjustment prospectively within 30 days of the date of the FI/MAC's determination that the applicable low-volume payment adjustment will apply to discharges occurring on or after the effective date of the hospital's low-volume status, within Federal FY 2011.

In order to implement this policy for FY 2011, the Pricer will include a new table containing the provider number and discharge count determined from the March 2010 update of the FY 2009 MedPAR file. The discharge count includes any Health Maintenance Organization (HMO)/Medicare Advantage claims, but will exclude any claims serviced in non-IPPS units. The table in Pricer will only hold providers with less than 1600 Medicare discharges and does not consider whether the provider meets the mileage criterion (that is, located more than 15 road miles from any other IPPS hospital).

The applicable low-volume percentage add-on payment is based on and in addition to any other IPPS payments, including capital, Disproportionate Share Hospital (DSH), Indirect Medical Education (IME), and outliers. For SCHs and MDHs, the applicable low-volume percentage add-on payment is based on and in addition to payment based on the Federal rate or the hospital-specific rate, whichever results in a greater payment.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org> on the Internet. This Website is expected to be

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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% Reporting Hospital Quality Data Annual Payment Update for FY 2011 are listed in Attachment B of CR 7134. The Web address for accessing CR 7134 is in the "Additional Information" section at the end of this article.

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

42 CFR 412.64(b)(II)(D)(3) (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr412.64.pdf on the Internet) implements the Social Security Act (section 1886(d)(8)(B); visit http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet), 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 will 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.)

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 DSH adjustment since these hospitals are considered rural under the capital PPS (see section 412.320(a)(1)). Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under section 412.103 is determined from the applicable statewide rural wage index.

Frontier Wage Index RFBN

The Affordable Care Act (Section 10324(a)(1); visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet) amended the Social Security Act (Section 1886(d)(3)(E); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet) by adding a provision under new subsection (iii) to establish an adjustment to create a wage index floor of 1.00 for all hospitals located in States determined to be "frontier States," beginning in FY 2011.

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For the final FY 2011 IPPS wage indices, CMS identified the following frontier States that will receive the floor adjustment for FY 2011. These frontier States also are identified by a footnote in Table 4D-2 of the Addendum to the final rule. Pricer will calculate all applicable frontier wage indexes.

Frontier States Identified for the FY 2011 Wage Index Floor Adjustment Under Section 10324(a) of the Affordable Care Act

State	Total Counties	Frontier Counties	Percent of Counties Identified As Frontier
Montana	56	45	80%
Wyoming	23	17	74%
North Dakota	53	36	68%
Nevada	17	11	65%
South Dakota	66	34	52%

Section 1109

Section 1109 of Pub. L. 111-152 provides for additional payments for FY 2011 and 2012 to "qualifying hospitals." Section 1109(d) defines a "qualifying hospital" as a "subsection (d) hospital [...] that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B [...] per enrollee within the lowest quartile of such counties in the United States." In the FY 2011 final rule, CMS provided tables with a list of qualifying hospitals, their payment weighting factors and eligible counties. As finalized in the FY 2011 final rule, CMS expects to distribute \$150 million for FY 2011 and \$250 million for FY 2012 to qualifying hospitals. CMS plans on distributing these payments through the individual hospital's Medicare contractor through an annual one-time payment during each of FY 2011 and FY 2012. CMS plans on issuing instructions to Medicare contractors subsequent to this notification on the distribution of these payments. Qualifying hospitals will report these additional payments on their Medicare hospital cost report corresponding to the appropriate cost reporting period that the hospitals receive the payments. CMS plans to issue additional cost reporting instructions for qualifying hospitals and Medicare contractors on how to report these additional payments. CMS notes that it is requiring these payments be reported on the cost report for tracking purposes only. These additional payments will not be adjusted or settled by the FI or MAC on the cost report.

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The Long-Term Care Hospital (LTCH) PPS FY 2011 Update
FY 2011 LTCH PPS Rates

Federal Rate	\$39,599.95
High Cost Outlier Fixed-Loss Amount	\$18,785.00
Labor Share	75.271%
Non-Labor Share	24.729%

MS-LTC-DRG Update

The LTCH PPS Pricer has been updated with the Version 28.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2010, and on or before September 30, 2011.

Cost of Living Adjustment (COLA) Update for LTCH PPS

LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

Changes to Certain LTCH PPS Payment Policies made by the Affordable Care Act of 2010

The Affordable Care Act (Section 3106 and 10312; visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet) provided for an extension of certain payment rules under the LTCH PPS and the moratorium on the establishment of certain LTCHs and LTCH satellites and the increase in number of beds in existing LTCHs and LTCH satellites. The changes required by sections 3106 and 10312 of the Affordable Care Act are self-implementing and were announced in the FY 2011 IPPS/LTCH PPS final rule, and CMS is revising sections 150.9.1.1 and 150.9.1.4 of the Medicare Claims Processing Manual (Chapter 3), which is included as an attachment to CR 7134 to reflect these changes as applicable.

The Inpatient Psychiatric Facility (IPF) PPS Update
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 Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and

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all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the 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 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 following table lists the FY 2011 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 2011 **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. Please note that there are no invalid ICD-9-CM diagnosis codes that impact the MS-DRG adjustment under the IPF PPS for FY 2011.

Diagnosis Code	Description	DRG Adjustment
799.51	Attention or concentration deficit	886
799.52	Cognitive communication deficit	884
799.54	Psychomotor deficit	884
799.55	Frontal lobe and executive function deficit	884
799.59	Other signs and symptoms involving cognition	884

The table below lists the FY 2011 **revised** ICD-9-CM diagnosis code that impacts the MS-DRG adjustment under the IPF PPS. The table only lists the FY 2011 **revised** code and does not reflect all of the currently valid ICD codes applicable for the IPF PPS MS-DRG adjustment.

Diagnosis Code	Description	MS-DRG
307.0	Adult onset fluency disorder	887

The table below lists the seventeen MS-DRG adjustment categories for which CMS is providing an adjustment, their respective codes and their respective adjustment factors. Please note that CMS does not plan to update the regression

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analysis until the IPF PPS data is analyzed. The MS-DRG adjustment factors, shown below, are effective October 1, 2010, and will continue to be paid for Rate Year (RY) 2011.

MS-DRG	MS-DRG Description	Adjustment Factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnosis of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neurosis	0.99
882	Neurosis except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

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

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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 and Complications (CCs) 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 shall 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-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 2011 GROUPER, Version 28.0 which is effective for discharges occurring on or after October 1, 2010.

The following table lists the FY 2011 **new** ICD-9-CM diagnosis codes which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. The table lists only the FY 2011 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2011 IPF Pricer will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2010. There are no invalid or revised ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS for FY 2011.

Diagnosis Code	Description	Comorbidity Category
237.73	Schwannomatosis	Oncology
237.79	Other neurofibromatosis	Oncology

The table below lists the seventeen comorbidity categories for which CMS is providing an adjustment, their respective codes, including the new FY 2011 ICD codes, and their respective adjustment factors.

Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13

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Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Tracheostomy	51900 through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V4511, V4512, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08

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Description of Comorbidity	ICD-9CM Code	Adjustment Factor
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Additional Information

The official instruction, CR 7134, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2060CP.pdf> on the CMS website.

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

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