

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the [2015 ICD-10-CM and GEMs](#) web page and [2015 ICD-10-PCS and GEMs](#) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: MM8761

Related Change Request (CR) #: CR 8761

Related CR Release Date: May 12, 2014

Effective Date: July 1, 2014

Related CR Transmittal #: R2951CP

Implementation Date: July 7, 2014

Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2014 Pricer

Provider Types Affected

This MLN Matters® article is intended for hospitals who submit claims to Medicare Claims Part A Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8761 updates the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) PRICER due to the Protecting Access to Medicare Act of 2014 and due to corrections of some uncompensated care per claim amounts. Make sure that your billing staff are aware of these updates.

Background

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, and the new law includes the extension of certain provisions of the Affordable Care Act. (See <http://www.gpo.gov>.)

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gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf on the Internet.) Specifically, the following Medicare fee-for-service policies have been extended through March 31, 2015:

- **Section 105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals**

The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 and 2012. To qualify, the hospital must:

- Have less than 1,600 Medicare discharges, and
- Be 15 miles or greater from the nearest like hospital.

The temporary changes to the low-volume hospital adjustment were extended for FY 2013 by the American Taxpayer Relief Act (see <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>), and from October 1, 2013 through March 31, 2014 by the Pathway for SGR Reform Act (<http://www.gpo.gov/fdsys/pkg/BILLS-113hjres59enr/pdf/BILLS-113hjres59enr.pdf>). The provision of the Protecting Access to Medicare Act of 2014 extends the temporary changes to the low-volume payment adjustment through March 31, 2015.

- **Section 106 - Extension of the Medicare-Dependent Hospital (MDH) Program**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision of the Protecting Access to Medicare Act of 2014 extends the MDH program until March 31, 2015. Prior to this legislation, the MDH program expired March 31, 2014, as provided by the Pathway for SGR Reform Act.

In addition, (consistent with the Centers for Medicare & Medicaid Services (CMS) policy finalized in the FY 2014 IPPS Final Rule (78 FR 50638; see <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm>)) CMS is making changes to the FY 2014 Factor 3, the total uncompensated care payments and the uncompensated care per claim amount for 38 providers included in Attachment A of CR8761, whose uncompensated care payments were inadvertently calculated using a cost report that was less than a full year when a cost report that was a full year or closer to being a full year was available.

The updated payments reflect revisions to Factor 3 such that Medicaid days in the numerator and denominator for all affected providers are based on:

- A full year cost report from 2011,
or if not available or if less than 12 months,
- A full year cost report from 2010, or
- The cost report from 2011 or 2010 that is closest to 12 months.

In addition, CMS is revising the uncompensated care per claim amount for one provider, whose uncompensated care per claim amount was inadvertently overstated, resulting in large

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interim overpayments. This provider is also included in Attachment A of CR8761.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014

The Affordable Care Act (Sections 3125 and 10314; see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>) amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. These amendments were extended for FY 2013 by the American Taxpayer Relief Act (ATRA; see <http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf>), and subsequently extended for FY 2014 discharges occurring before April 1, 2014, by the Pathway for SGR Reform Act. Prior to the Protecting Access to Medicare Act of 2014, for FY 2014 discharges occurring on or after April 1, 2014, and subsequent years, the low-volume hospital qualifying criteria and payment adjustment returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and subsequent legislation.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring on or after April 1, 2014, provided for by section 105 of the Protecting Access to Medicare Act (quoted above), in accordance with the existing regulations at CFR 412.101(b)(2)(ii) and consistent with current policy, CMS published a notice in the Federal Register (CMS 1599-N).

In that notice, CMS established that for FY 2014 discharges occurring on or after April 1, 2014, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files (that is, the same discharge data used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred during the first half of FY 2014). In Table 14 of the Addendum to that notice, CMS republishes the list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files (originally published in CMS 1599-IFC2). This list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2014 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital must also be located more than 15 road miles from any other IPPS hospital). **In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2014 discharges occurring on or after April 1, 2014, a hospital must meet both the discharge and mileage criteria.**

In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, a hospital must make its request for low-volume hospital status in writing to its Medicare Contractor and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or

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after April 1, 2014. The MAC must be in receipt of the hospital's written request by June 30, 2014, in order for the effective date of the hospital's low-volume hospital status to be April 1, 2014. **A hospital that qualified for the low-volume payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013, through March 31, 2014, does not need to notify its MAC and will continue to receive the applicable low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, without reapplying, provided it continues to meet the Medicare mileage criterion.**

A hospital that qualified for the low-volume payment adjustment in FY 2013 but failed to make the required notification to its MAC by the deadline for its discharges occurring during the first half of FY 2014 may begin receiving the applicable low-volume payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014, without reapplying, if it meets the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of that notice) and the distance criterion. **However, the hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than June 30, 2014.** For requests for low-volume hospital status for FY 2014 discharges occurring on or after April 1, 2014, received after June 30, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC's low-volume status determination, consistent with CMS historical policy. Hospital requests for low-volume hospital status received between the issuance of the Federal Register notice that implements the provisions of section 105 (quoted above) of the Protecting Access to Medicare Act through June 30, 2014, are **only applicable for FY 2014 discharges occurring on or after April 1, 2014** (and will not be applied in determining payments for the hospital's FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates).

MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the Federal Register Notice (CMS-1599-N) and available on the Acute Inpatient PPS webpage at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp (click on the link on the left side of the screen titled, "FY 2014 IPPS Final Rule Home Page"). CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR file.) The Medicare discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units.

In order to implement this policy for FY 2014, the Pricer will continue to include the table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file. The table in the Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

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The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole-Community Hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare Dependent Hospital (MDH) Status

Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended for FY 2013 by section 606 of the American Taxpayer Relief Act, and from October 1, 2013, through March 31, 2014, by the Pathway for SGR Reform Act. As part of the Protecting Access to Medicare Act, Congress reinstated the MDH program through March 31, 2015.

CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in:

- The regulations at 42 CFR 412.108 (see <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.13>);
- The FY 2011 IPPS/LTCH PPS final rule (75 FR 50287; see <http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm>);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649; see <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm>); and
- The FY 2014 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final rule with Comment (IFC) (March 18, 2014; 79 FR 15025 through 15028); see <http://www.gpo.gov/fdsys/pkg/FR-2014-03-18/pdf/2014-05922.pdf> on the Internet.

Consistent with the CMS implementation of previous MDH program extensions, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2014, with no need to reapply for MDH classification. There are the following two exceptions:

a. MDHs that classified as Sole-Community Hospitals (SCHs) on or after April 1, 2014

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by March 1, 2014, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2014. Additionally, some hospitals that had MDH status as of the March 31, 2014, expiration of the MDH program may have missed the March 1, 2014, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2014.

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b. MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification. You can review 42 CFR 412.103 at <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.8> on the Internet.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2014. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2014. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (412.108(b)(4)).

You can review 42 CFR 412.108 at <http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.13> on the Internet.

Cancellation of MDH Status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must “**evaluate on an ongoing basis**” whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Attachment B of CR8761 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.

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Hospital Specific (HSP) Rate Update for MDHs

For the payment of FY 2014 discharges occurring on or after April 1, 2014, the Hospital Specific (HSP) amount for MDHs in the Provider Specific File will continue to be entered in FY 2012 dollars (just as was done for SCHs as instructed in CR 8241 (Transmittal 2778; August 30, 2013)). PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

Uncompensated Care Payment

There is no change to the existing policy.

Additional Information

The official instruction, CR 8761 issued to your MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2951CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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