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News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The *RA Guide* is available as a downloadable document from the Medicare Learning Network Publications web page. To download and view, please go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

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Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

Note: This article was updated on September 20, 2012, to reflect current Web addresses. This article was also revised on February 17, 2009, to remove outdated Web links that no longer work. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries And paid under the IPPS, the LTCH PPS, or the IPF PPS.

Provider Action Needed

This article is based on Change Request (CR) 5748, which announces changes to the IPPS and LTCH PPS payment policies based on the FY 08 IPPS Final Rule. It also includes the ICD-9-CM coding changes that affect the IPF PPS comorbidity adjustment. The FY 08 IPPS Final Rule also established a new diagnosis-related group (DRG) system, the Medicare Severity DRGs, or MS-DRGs, effective October 1, 2007. Be sure billing staff are aware of the changes.

Background

The Centers for Medicare & Medicaid Services (CMS) annually updates the Inpatient Prospective Payment System (IPPS), and CR5748 announces changes for the IPPS hospitals for Fiscal Year (FY) 2008. The policy changes for FY 2008 appeared in the Federal Register on August 22, 2007 (*http://www.access.gpo.gov/su_docs/fedreg/a070822c.html*) and the final IPPS rates are available on the CMS website. All items covered in CR5748 are effective for hospital discharges occurring on or after October 1, 2007, unless otherwise noted.

The FY 08 IPPS Final rule established a new DRG system, the MS-DRGs, effective October 1, 2007. By better taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. To assure that improvements in coding and documentation do not lead to an increase in the aggregate payments without corresponding growth in actual patient severity, the final rule established a documentation and coding adjustment of -1.2 percent for FY 2008. However, Section 7 of the "TMA, Abstinence Education, and QI Programs Extension Act of 2007" limits that adjustment to -0.6 percent for discharges occurring in FY 2008. This -0.6 percent adjustment is not being applied to the hospital-specific rates in the Pricer. This is consistent with the policy established in the IPPS notice issued on November 1, 2007.

CR 5748 also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2007 for hospitals paid under the IPPS, as well as under Long Term Care Hospital (LTCH) PPS. LTCH PPS rate changes occurred on July 1, 2007. (Please refer to CR 5652 (Transmittal 1268, published on June 15, 2007 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1268CP.pdf or its corresponding MLN Matters articles MM5652 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5652.pdf on the CMS website for LTCH policy changes).

The Inpatient Psychiatric Facility (IPF) PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2007. Rate changes occurred on July 1, 2007. Please refer to CR 5619 (Transmittal 1256, published on May 25, 2007 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1256CP.pdf or it corresponding MLN Matters article MM5619 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5619.pdf on the CMS website) for IPF PPS policy changes.

ICD-9-CM coding changes are effective October 1, 2007. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6A and 6B of the August 22, 2007, Federal Register , and 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. You can also find the revised code titles in Tables 6E and 6F in the August 22, 2007 Federal Register (Pages 47129-48175).

A new DRG Grouper, Version 25, software package is effective for discharges on or after October 1, 2007. GROUPER 25.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2007. The Medicare Code Editor (MCE) 24.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2007. Key changes in CR5748 are as follows:

A. Furnished Software Changes

The following software programs were issued for FY 2008:

IPPS PRICER 08.0

The IPPS Pricer, version 08.0, will be used for discharges occurring on or after October 1, 2007. The IPPS Pricer 08.0 also processes bills with discharge dates on or after October 1, 2002.

Rates

Standardized Amount Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$22,185.00
Federal Capital Rate	$426.14
Puerto Rico Capital Rate	$201.67
Outlier Offset-Operating National	0.948983
Outlier Offset-Operating Puerto Rico	0.964060
Indirect medical education (IME) Formula	1.35*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor	0.995743

Operating Rates:

Rates With Full Market Basket & Wage Index Greater than 1

	Labor Share	Non-Labor Share
National	3478.45	1512.15
Puerto Rico/ National	3478.45	1512.15
Puerto Rico Specific	1462.27	896.23

Rates With Full Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3094.17	1896.43
Puerto Rico/ National	3094.17	1896.43
Puerto Rico Specific	1384.44	974.06

Rates With Reduced Market Basket & Wage Index Greater Than 1

	Labor Share	Non-Labor Share
National	3411.10	1482.87

Rates With Reduced Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3034.26	1859.71

Cost-of-Living Adjustment Factors - Alaska and Hawaii Hospitals:

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Postacute Care Transfer Policy

The Diagnosis Related Groups (DRGs) determined in the post acute care transfer policy have been modified due to Medicare Severity Diagnosis Related Groups (MS-DRGs). See Section B (Grouper 25.0) below regarding MS-DRGs.

The special pay DRGs are paid at 50% of the appropriate PPS rate for the first day of the stay and 50% of the amount calculated for the rest of the stay. These special pay DRGS are as follows:

028	029	030	040	041
042	219	220	221	477
478	479	480	481	482
492	493	494	500	501
502	515	516	517	956

Note: See attachment A of CR5748 for list of the postacute care transfer DRGs.

New Technology Add-On Payment

Effective for discharges on or after October 1, 2007, there will be no continuing add-on payments from last year and no new ones starting for this year.

Burn DRGs

Burn DRGs receive 90 percent of costs exceeding the outlier threshold instead of the 80 percent that other DRGs receive. The Burn DRGs for FY08 are 927, 928, 929, 933, 934 and 935. These have been updated for MS-DRGs.

B. GROUPER 25.0

For discharges occurring on or after October 1, 2007,, PRICER calls the appropriate GROUPER based on discharge date. This version of Grouper will include logic to group to MS-DRGS. Grouper will have increased field lengths for the diagnosis and procedure codes and dates and fields for the Present on Admission (POA) indicator. The Medicare Severity DRGs or MS-DRGs are modifications of the CMS-DRGs to better account for severity of illness and resource consumption for Medicare patients. The MS-DRGs increase the number of DRGs by 207 to a total of 745, while maintaining the reasonable patient volume in each DRG. There are three levels of severity in the MS-DRGs based on the secondary diagnosis codes: MCC (Major Complication/Comorbidity), CC (Complication/Comorbidity), and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the CMS DRGs or the MS-DRGs.

C. Medicare Code Editor (MCE) 24.0

For discharges occurring on or after October 1, 2007, the MCE selects the proper internal tables based on discharge date. Effective October 1, 2007, MCE will have increased field lengths for diagnosis and procedure codes, fields for the POA indicator, other new edits and retroactivity.

D. Provider Specific Information

Tables 8A and 8B of Section VI of the addendum to the PPS final rule contain the FY 2008 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.238 and the capital ceiling is 0.152. See the August 22, 2007 Federal Register (Pages 47129-48175).

Core-Based Statistical Area (CBSA) Designations

Attachment B of CR5748 shows the IPPS providers that will be receiving a "special" wage index for FY 2008 (i.e., receives an out-commuting adjustment under section 505 of the Medicare Modernization Act (MMA)).

For any provider with a Special Wage Index from FY 2007, Fiscal Intermediaries (FIs) shall remove that special wage index, unless they receive a new special wage index as listed in Attachment B of CR5748.

Micropolitan areas are "rural" areas, but hospitals in these areas were given an urban area wage index for 3 years (known as the hold harmless provision. This provision expired on September 30, 2007 and these hospitals now receive 100 percent of their wage index based upon the CBSA configurations.

Low Volume Hospitals

Hospitals considered low volume will receive a 25% bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify FIs 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. If the hospital is no longer low volume, the 'Y' indicator should be removed. If the hospital does meet the low volume criteria, a 'Y' should be inserted into the low volume indicator field.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at http://www.qualitynet.org on the Internet. Attachment C of CR5748 includes the list of providers that did not meet the criteria for FY 08. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website and FIs must update the provider file as needed.

For new hospitals, FIs will provide information to the appropriate Quality Improvement Organization (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

E. Other Changes

Capital PPS Adjustment for Hospitals Located in Large Urban Areas

In the FY 2008 final rule, the capital PPS 3.0 percent "large urban add-on" was eliminated effective for discharges on or after October 1, 2007. That is, the regulations at §412.316(b) were revised to specify that beginning in FY 2008 and after, there will no longer be any additional payment under the capital PPS for hospitals located in large urban areas, as currently provided under that section. The PRICER has been updated to reflect this policy change.

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

Under this section of the Act, certain rural counties (commonly referred to as "Lugar counties") adjacent to one or more urban areas are redesignated as urban for the purposes of payment under the IPPS. Hospitals located in these "Lugar counties" are deemed to be located in an urban area and they receive the Federal payment amount for the urban area to which they are redesignated. Such hospitals, however, may decline this redesignation and retain their rural status.

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

Hospitals reclassified as rural under 42 CFR 412.103 (http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1); http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html). Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under 42 CFR 412.103 is determined from the applicable statewide rural wage index.

F. LTCH Changes

A new patient classification system is being adopted under the LTCH PPS , beginning in FY 2008. It is the same as the one being adopted under the IPPS (i.e., MS-DRGs), but under LTCH, the DRGs are referred to as "MS-LTC-DRGs". The LTCH PRICER has been updated with the MS-LTC-DRG table and weights.

In the IPPS computation of the "IPPS Comparable Amount" for LTCH Short-Stay Outlier (SSO) cases, in the calculation of the Capital IPPS comparable payment amount, the 3% large urban add-on has been eliminated effective with discharges occurring on or after October 1, 2007.

G. Inpatient Psychiatric Facility Changes

Coding Changes -DRG Adjustment Update:

The IPF PPS has DRG specific adjustments for 15 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 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 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being

updated, please note these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS- DRGs, which will be effective October 1, 2007.

(Version 24) DRG	(Version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521- 522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
	896	Alcohol/drug abuse or	

(Version 24) DRG	(Version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
523	897	dependence w/o rehabilitation therapy w MCC 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 of co-morbid 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.

Co-morbidities 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. Co-morbid 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.

As explained above, the IPF PPS is adopting the new MS-Severity DRG coding system in order to maintain consistency with the IPPS, which are effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. The FY 2008 GROUPER, Version 25.0, is effective for discharges occurring on or after October 1, 2007.

There are two tables in CR5748 listing the FY 2008 new ICD-9-CM diagnosis codes and the one invalid FY 2008 ICD diagnosis code, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2008 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

One table in CR5748 is an extensive table that lists the FY 2008 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2008 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. CR5748 can be accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1374CP.pdf on the CMS website.

There is one ICD-9-CM codes no longer applicable for the comorbidity adjustment. This code is:

Diagnosis Code	Description	Comorbidity Category
233.3	Carcinoma in situ, other and unspecified female genital organs	Oncology Treatment

Additional Information

The official instruction (CR5748) issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1374CP.pdf on the CMS website.

If you have any questions, please contact your Medicare intermediary 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.