DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – The "Inpatient Psychiatric Facility Prospective Payment System" fact sheet is now available in print format. This fact sheet is designed to provide education on the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and includes the following information: background, coverage requirements, how payment rates are set, and Rate Year 2012 update to the IPF PPS. To place your order, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

MLN Matters® Number: MM7508 Revised

Related Change Request (CR) #: 7508

Related CR Release Date: August 26, 2011

Effective Date: October 1, 2011

Related CR Transmittal #: R2291CP

Implementation Date: October 3, 2011

Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Changes

Note: This article was updated on August 8, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7508, which provides:

- Fiscal Year (FY) 2012 updates to the Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Prospective Payment System

(PPS);
- FY 2012 updates to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding; and
- Changes to payment for CAH ambulance services.

All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted. Be sure your staffs are aware of these changes.

Background

This article, based on CR7508, outlines changes to the IPPS for Acute Care Hospitals and the PPS for Long Term Care Hospitals (LTCHs) for FY 2012. The policy changes for FY 2012 appeared in the Federal Register on August 1, 2011.

The websites for the final rule, tables and data files noted are as follows:

- The FY 2012 IPPS final rule is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

- The IPPS tables for the final rule are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html on the CMS website. Click on the link on the left side of the screen titled, "FY 2012 IPPS Final Rule Home Page" or "Acute Inpatient – Files for Download."

- The LTCH PPS tables for the FY 2012 final rule are available under the list item for Regulation Number CMS-1518-F at
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html on the CMS website.

This article also addresses the FY 2012 update to the MS-DRGs and ICD-9-CM coding.

All items covered in this article are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted. A summary of the changes is as follows:

ICD-9-CM Changes

The ICD-9-CM coding changes are effective October 1, 2011. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the

August 1, 2011, Federal Register. The ICD-9-CM codes that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f.

A new MS-DRG Grouper, Version 29.0, software package was introduced and is effective for discharges on or after October 1, 2011. The GROUPER 29.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare Code Editor (MCE) Version 28.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2011.

The IPPS FY 2012 Update

The FY 2012 IPPS Pricer will be provided to Medicare's Fiscal Intermediary Shared System (FISS) for discharges occurring on or after October 1, 2011. It includes all pricing files for FY 2006 through FY 2012 to process bills with discharge dates on or after October 1, 2005.

FY 2012 IPPS Rates

Standardized Amount Update Factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$22,385
Federal Capital Rate	$421.42
Puerto Rico Capital Rate	$203.86
Outlier Offset-Operating National	0.94899
Outlier Offset-Operating Puerto Rico	0.953549
IME Formula (no change for FY12)	1.35 x [(1 + resident to bed ratio)$^{.405}$ – 1]
MDH/SCH Budget Neutrality Factor	0.997903
MDH/SCH Documentation and Coding Adjustment Factor	0.9528
MDH/SCH Adjustment for Restoration of Rural Floor Budget Neutrality	1.009

Operating Rates

Operating Rates with Full Market Basket and Wage Index > 1	
National Labor Share	$3,584.30
National Non Labor Share	$1,625.44
PR National Labor Share	$3,584.30
PR National Non Labor Share	$1,625.44
Puerto Rico Specific Labor Share	$1,553.29
Puerto Rico Specific Non Labor Share	$947.98
Operating Rates with Full Market Basket and Wage Index < or = 1	
National Labor Share	$3,230.04
National Non Labor Share	$1,979.70
PR National Labor Share	$3,230.04
PR National Non Labor Share	$1,979.70
Puerto Rico Specific Labor Share	$1,550.79
Puerto Rico Specific Non Labor Share	$950.48
Operating Rates with Reduced Market Basket and Wage Index > 1	
National Labor Share	$3,513.95
National Non Labor Share	$1,593.54
PR National Labor Share	$3,584.30
PR National Non Labor Share	$1,625.44
Puerto Rico Specific Labor Share	$1,553.29
Puerto Rico Specific Non Labor Share	$947.98
Operating Rates with Reduced Market Basket and Wage Index < or = 1	
National and PR National Labor Share	$3,166.64
National and PR National Non Labor Share	$1,940.85
PR National Labor Share	$3,230.04
PR National Non Labor Share	$1,979.70
Puerto Rico Specific Labor Share	$1,550.79
Puerto Rico Specific Non Labor Share	$950.48

Post-acute Transfer and Special Payment Policy

The following MS-DRGs will be listed as qualifying for post-acute transfer policy status as of FY 2012:

- MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex CNS PDX with MCC);
- MS-DRG 024 (Craniotomy with Major Device Implant or Acute Complex CNS PDX without MCC);
- MS-DRG 570 (Skin Debridement with MCC);
- MS-DRG 571 (Skin Debridement with CC); and

- MS-DRG 572 (Skin Debridement without CC/MCC).

The following MS-DRGs will no longer be listed as qualifying for post-acute transfer policy status as of FY 2012:

- MS-DRG 228 (Other Cardiothoracic Procedures with MCC),
- MS-DRG 229 (Other Cardiothoracic Procedures with CC); and
- MS-DRG 230 (Other Cardiothoracic Procedures without CC/MCC).

The following MS-DRGs will be listed as qualifying for special payment policy status as of FY 2012:

- MS-DRG 216 (Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC);
- MS-DRG 217 (Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC); and
- MS-DRG 218 (Cardiac Valve & Other Major Cardiothoracic Procedure without CC/MCC).

A listing of all Post-acute and Special Post-acute MS-DRGs may be found in Table 5 of the FY 2012 IPPS final rule.

New Technology Add-On Payments

The following item is eligible for new-technology add-on payments in FY 2012:

Continue payments for the AutoLITT - 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 an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). 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 Adjustment Factors

The wage table loaded for the FY 2012 Pricer contains wage index values already adjusted by the national rural floor budget neutrality factor of 0.991007.

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2012. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS PPS final rule.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act and as extended by both the Affordable Care Act and the Medicare and Medicaid Extenders Act of 2010 (MMEA) will no longer be in effect beginning October 1, 2011.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A to the CR7508 (Section 505) shows the IPPS providers that will be receiving a "special" wage index for FY 2012 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Hospitals Waiving Lugar Redesignation for the Out-Migration Adjustment

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status and is considered rural for all IPPS purposes. Below is the list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2012:

Medicare CMS Certification Number (CCN)	Provider Name
010164	COOSA VALLEY MEDICAL CENTER
360096	EAST LIVERPOOL CITY HOSPITAL
390150	SOUTHWEST REGIONAL MEDICAL CENTER
390201	POCONO MEDICAL CENTER

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

For FY 2012, the HSP rates for SCHs and MDHs will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2012 is 1.9 percent (or -0.10 percent for hospitals that do not submit quality data) and the budget neutrality factor for DRG reclassification and recalibration is 0.997903. For FY 2012, a cumulative documentation and coding adjustment factor of 0.9528 will be applied to the HSP rates (this factor includes the permanent 2.9 percent reduction implemented in FY 2011 and the additional permanent 2.0 percent

reduction implemented beginning in FY 2012). Beginning in FY 2012, a permanent adjustment for restoring rural floor budget neutrality of 1.009 will also be applied to the HSP rates.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2012

Sections 3125 and 10314 of the Affordable Care Act 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. CMS implemented these changes to the low-volume payment adjustment in the regulations at section 412.101 in the FY 2011 IPPS final rule (75 FR 50238 through 50275).

In the FY 2012 IPPS final rule, CMS established that for FY 2012 the low-volume payment adjustment will be determined using FY 2012 Medicare discharge data from the March 2011 update of the Medicare Provider Analysis and Review (MEDPAR) files. In Table 14 of the Addendum to the final rule, CMS provided a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2011 update of the FY 2010 MedPAR files. However, 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 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 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 2012, a hospital must meet both the discharge and mileage criteria.

CMS established a procedure for a hospital to request low-volume hospital status for FY 2012 in the FY 2012 IPPS final rule, which is similar to the procedure established for the FY 2011 low-volume payment adjustment (see MM7134, October 1, 2010, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7134.pdf on the CMS website).

- For FY 2012, a hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by September 1, 2011, so that the applicable low-volume percentage add-on can be applied to payments for its discharges occurring on or after October 1, 2011.
- A hospital that qualified for the low-volume payment adjustment in FY 2011 may continue to receive a low-volume payment adjustment in FY 2012, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2010 MedPAR data (shown in Table 14 of the Addendum to the final rule) and the distance criterion. However, the hospital must verify in

writing to its FI or MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than September 30, 2011.

- For requests for low-volume hospital status for FY 2012 received after September 1, 2011, if the hospital meets the criteria to qualify as a low-volume hospital, the FI or MAC will apply the applicable low-volume payment adjustment in determining payments to the hospital's FY 2012 discharges prospectively within 30 days of the date of the FI's or MAC's low-volume status determination.

The applicable low-volume percentage add-on payment is based on and is in addition to all other IPPS per discharge 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 is in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital Quality Initiative

Hospitals that will receive the quality initiative bonus are listed at https://www.qualitynet.org/ on the Internet. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website. A list of hospitals not receiving the 2.0% RHQDAPU annual payment update for FY 2012 will be available in September.

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

42 Code of Federal Regulations (CFR) 412.64(b)(II)(D)(3) implements Section 1886(d)(8)(B) of the Social Security Act, available at http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol2/pdf/CFR-2009-title42-vol2-sec412-64.pdf which re-designates 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.

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 Rural Floor Budget Neutrality (RFBN)

The Affordable Care Act established 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 2012.

For the final FY 2012 IPPS wage indices, CMS identified the following frontier States that will receive the floor adjustment for FY 2012: Montana, Nevada, North Dakota, South Dakota, and Wyoming.

Section 1109

Section 1109 of the Health Care and Education Reconciliation Act of 2010 provides for additional payments for FYs 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 IPPS final rule, CMS provided tables with a list of qualifying hospitals, their payment weighting factors and eligible counties. As finalized in the FY 2011 IPPS final rule, CMS expects to distribute $150 million for FY 2011 and $250 million for FY 2012 to qualifying hospitals.

CMS' payment distribution process uses a single Medicare contractor that will directly pay all of the qualifying hospitals annually for FY 2011 and for FY 2012. CMS distributed $150 million for FY 2011 in July 2011 and plans on distributing the remaining $250 million for FY 2012 sometime after November 1, 2011, to qualifying hospitals.

LTCH PPS FY 2012 Update

FY 2011 LTCH PPS Rates

Federal Rate	$40,222.05
High Cost Outlier Fixed-Loss Amount	$17,931
Labor Share	70.199%
Non-Labor Share	29.801%

MS-LTC-DRG Update

The LTCH PPS Pricer has been updated with the Version 29.0 Medicare Severity Long-Term Care-Diagnosis Related Group (MS-LTC-DRG) table and weights, effective for discharges occurring on or after October 1, 2011, and on or before September 30, 2012.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2012. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS final rule.

Core-Based Statistical Area (CBSA)-based Labor Market Definition Changes

There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2012. The CBSAs definitions and codes that will continue to be effective October 1, 2011 can be found in Table 12A to the Addendum of the FY 2012 IPPS final rule.

Inclusion of Medicare Advantage (MA) Days in the Average Length of Stay Calculation

The average Length of Stay (ALOS) calculation at 42 CFR 412.23(e)(3) specifies that all data on all Medicare inpatient days, including MA inpatient days, must be included in the average length of stay calculation. When evaluating whether an LTCH meets the average ALOS requirement at Section 412.23(e)(3), based upon a policy clarification included in the FY 2012 IPPS final rule, no LTCH should lose its exclusion from the IPPS (i.e., its status as an LTCH) because of the inclusion of MA inpatient days in the calculation of its ALOS until LTCH cost reporting periods beginning on or after January 1, 2012.

Additional LTCH Policy Changes for FY 2012

In the FY 2012 IPPS final rule, the moratorium on the increase in number of beds has been extended to also apply to LTCHs and LTCH satellites that were established under one of the exceptions to the moratorium provided in Section 114(d) of the MMSEA. Specifically, the number of beds in those LTCHs and LTCH satellites must not be beyond the number certified by Medicare on October 1, 2011.

Changes to Payment for CAH Ambulance Services

Effective with dates of service on or after October 1, 2011, in order for a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH. Prior to October 1, 2011, the regulations required that there be no other provider or supplier of ambulance services within a 35-mile drive of the CAH or the entity.

Effective with dates of service on or after October 1, 2011, if there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH but there is a CAH-owned and operated entity located more than a 35-mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable

costs for its ambulance services, if it is the closest provider or supplier of ambulance services to the CAH.

Additional Information

The official instruction, CR7508, 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/R2291CP.pdf on the CMS website.

The FY 2012 IPPS final rule, including Data Files and Tables, is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html on the CMS website.

The IPPS tables for the final rule are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html on the CMS website. Click on the link on the left side of the screen titled, "FY 2012 IPPS Final Rule Home Page" or "Acute Inpatient – Files for Download."

The LTCH PPS tables for the FY 2012 final rule are available, under the list item for Regulation Number CMS-1518-F, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html 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.