CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1816	**Date: September 17, 2009**
	Change Request 6634

Transmittal 1815, Change Request 6634, dated September 9, 2009, is being rescinded and replaced to provide technical clarification to business requirements 6634.4.1.3. A X-ref requirement was added for business requirement 6634.4.1.3. Provider 190258 was removed from Attachment B. In the manual update to Chapter 32, the word denied is replacing rejected. All other material remains the same.

Subject: Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

I. SUMMARY OF CHANGES: This CR provides the FY 2010 update to the IPPS, LTCH PPS, and the IPF PPS. Internet Only Manual updates are incorporated within this Recurring Notification. Please note: no text was added to Section 150.9.1.3. Only a flow chart and some associated language referencing the flow chart was removed from this section. The only change made in Chapter 3, Section 140.3.1, was the deletion of the following statement: "(For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge)."

New / Revised Material
Effective Date: Discharges on or after October 1, 2009
Implementation Date: October 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3 - Table of Contents
R	3/20.1 - Hospital Operating Payments Under PPS
R	3/20.1.2.3 - Threshold and Marginal Cost
R	3/20.2.1 - Medicare Code Editor (MCE)
N	3/20.3.1.3 - Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009
R	3/20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

R	3/40.3 - Outpatient Services Treated as Inpatient Services
R	3/90.1.1 - The Standard Kidney Acquisition Charge
R	3/90.2 - Heart Transplants
R	3/90.4.2 - Billing for Liver Transplant and Acquisition Services
R	3/90.5 - Pancreas Transplants Kidney Transplants
R	3/90.5.1 - Pancreas Transplants Alone (PA)
R	3/90.6 - Intestinal and Multi-Visceral Transplants
R	3/100.8 - Replaced Devices Offered Without Cost or With a Credit
R	3/140.3.1 - Shared Systems and CWF Edits
R	3/150.9.1.3 - Payments for Special Cases
R	3/150.9.1.4 - Payment Policy for Co-Located Providers
R	32/230 - Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1816	Date: September 17, 2009	Change Request: 6634

Transmittal 1815, Change Request 6634, dated September 9, 2009, is being rescinded and replaced to provide technical clarification to business requirements 6634.4.1.3. A X-ref requirement was added for business requirement 6634.4.1.3. Provider 190258 was removed from Attachment B. In the manual update to Chapter 32, the word denied is replacing rejected. All other material remains the same.

SUBJECT: Fiscal Year (FY) 2010 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS Changes

Effective Date: Discharges on or after October 1, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes for IPPS hospitals and LTCHs for FY 2010. The policy changes for FY 2010 appeared in the Federal Register on August 27, 2009. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2009, unless otherwise noted.

This CR also addresses the FY 2010 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and ICD-9-CM coding. The coding changes require an update to the IPF PPS' comorbidity adjustment, effective October 1, 2009. (Note: The IPF PPS rate changes occurred on July 1, 2009. Refer to Transmittal 1780, CR 6461, issued on July 24, 2009 for IPF PPS policy changes.)

B. Policy:

ICD-9-CM Changes

The ICD-9-CM coding changes are effective October 1, 2009. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables and 6a and 6b of the August 27, 2009, Federal Register. 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 Grouper Contractor, 3M-HIS, introduced a new MS-DRG Grouper, Version 27.0, software package effective for discharges on or after October 1, 2009. The GROUPER 27.0 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 26.0 which is also developed by 3M-HIS, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2009.

GROUPER 27.0 (for discharges occurring on or after October 1, 2009) – FISS calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation on or about August 1, 2009.

Medicare Coding Editor (MCE) 26.0 (for discharges occurring on or after October 1, 2009) – The MCE selects the proper internal tables based on discharge date. Medicare contractors should receive the MCE documentation on or about August 1, 2009. In that documentation, contractors will note the addition of a new edit, effective for discharges on or after October 1. 2009, edit #18 – Wrong Procedure Performed. Edit #18 is explained further in The Medicare Claims Processing Manual, Chapter 3, Section 20.2.1.

The Inpatient Prospective Payment System (IPPS) FY 2010 Update

The FY 2010 IPPS Pricer is released to the Fiscal Intermediary Shared System (FISS) for discharges occurring on or after October 1, 2009. It includes all pricing files for FY2005 through FY 2010 to process bills with discharge dates on or after October 1, 2004.

FY 2010 IPPS Rates

Standardized Amount Update Factor	1.021 1.001 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.021 1.001 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$23,140.00
Federal Capital Rate	$429.26
Puerto Rico Capital Rate	$203.56
Outlier Offset-Operating National	0.948994
Outlier Offset-Operating Puerto Rico	0.957524
IME Formula (no change for FY10)	$1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$
MDH/SCH Budget Neutrality Factor	0.997941

Operating

Rates with FULL Market Basket

	Wage Index > 1		Wage Index ≤ 1	
	Labor Share	Non-Labor Share	Labor Share	Non-Labor Share
National	$3,593.52	$1,629.62	$3,238.35	$1,984.79
PR National	$3,593.52	$1,629.62	$3,238.35	$1,984.79
PR Specific	$1,542.72	$941.52	$1,540.23	$944.01

Rates with REDUCED Market Basket

	Wage Index > 1		Wage Index ≤ 1	
	Labor Share	Non-Labor Share	Labor Share	Non-Labor Share
National	$3,523.13	$1,597.70	$3,174.91	$1,945.92
PR National	$3,523.13	$1,597.70	$3,174.91	$1,945.92
PR Specific	$1,542.72	$941.52	$1,540.23	$944.01

Cost-of-Living Adjustment (COLA) Factors: Alaska and Hawaii Hospitals

Area	COLA Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change for FY 2010)

Note: There are no COLA changes for Hawaii in FY 2010.

Postacute Transfer Policy

See Table 5 of the IPPS Final Rule for a listing of all Postacute and Special Postacute MS-DRGs.

New Technology Add-On Payments

The following items are eligible for new-technology add-on payments in FY 2010:

- Total Artificial Heart (TAH-t) – Effective in FY2009 and through FY 2010, 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 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, cases involving the Spiration® IBV® that are eligible for the new technology add-on payment 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. The maximum add-on payment for the Spiration® IBV® is $3,437.50 per case.

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.

State Rural Floor Budget Neutrality Adjustment Factors

The FY2009 IPPS Pricer included a new Pricer table, "State Rural Floor Budget Neutrality Adjustment Factors", due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570). "Specifically, CMS must make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) and the imputed floor under § 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected. Beginning October 1, 2008, such payments transition from a nationwide adjustment, with a statewide adjustment fully in place by October 1, 2011."

The table in Attachment A lists the blended overall rural floor budget neutral factors, for FY 2010, that are to be applied onto the wage index (based on the providers' geographic state location). The wage table loaded for the FY 2010 Pricer contains wage index values PRIOR to the application of the blended overall rural floor budget neutrality factors. The Pricer software is applying the budget neutrality factors from Attachment A to the wage index within the Pricer payment logic. The wage index tables printed in the FY 2010 Federal Register Final Rule Notice already have the blended overall rural floor budget neutrality factors applied. 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 multiply it by the appropriate factor from Attachment A.

Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update the all applicable fields for IPPS hospitals effective October 1, 2009, or effective with cost reporting periods that begin on or after October 1, 2009, or upon receipt of an as-filed (tentatively) settled cost report.

Note: Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2010 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.179 and the capital ceiling is 0.148.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act will expire on October 1, 2009. The PSFs shall be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment B shows the IPPS providers that will be receiving a "special" wage index for FY 2010 (i.e., receive an out-commuting adjustment under section 505 of the MMA). For any provider with a Special Wage Index from FY 2009, FIs and A/B MACs shall remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in Attachment B.

Low Volume Hospitals

Fiscal Intermediaries (FIs) and A/B MACs shall enter a 'Y' in position 74 (Temporary Relief Indicator) if the hospital is considered "low volume". Hospitals considered low volume shall receive a 25 percent 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 their FI or A/B MAC if they believe they are a low volume hospital. The Low Volume hospital status shall 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 shall be removed. If the hospital does meet the low volume criteria, a 'Y' shall be inserted into the low volume indicator field.

Hospital Quality Initiative

The FIs and A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that meets the criteria for higher payments per MMA Quality standards. Leave blank if they don't meet the criteria. The hospitals that will receive the quality initiative bonus are listed at the following Web site: **www.qualitynet.org.** This Web site is expected to be 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 Web site, and FIs and A/B MACs shall update the provider file as needed. Hospitals not receiving the 2.0% RHQDAPU annual payment update for FY 2010 s are listed in Attachment C of this CR.

For new hospitals, FIs and A/B MACs shall enter a '1' in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and 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.

The FIs and A/B MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following:

- State Code
- Provider Name
- Provider ID number
- Medicare Accept Date
- Contact Name (if available)
- Telephone Number

Capital IPPS Adjustment for Indirect Medical Education (IME)

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule, we adopted a policy to phase-out the capital IPPS teaching adjustment. For FY 2009, hospitals would receive 50 percent of the IME adjustment provided under the current formula. Section 4301(b) of the American Recovery and Reinvestment Act (ARRA) removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full

capital IME amount for discharges occurring on or after October 1, 2008 through September 30, 2009 (per CR 6444 issued on March 27, 2009).

The capital teaching adjustment is no longer being eliminated for FY 2010. Therefore, the full capital IME teaching adjustment is restored for FY 2010 and will be determined under §412.322(b).

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

42 CFR 412.64(b)(II)(D)(3) implements section 1886(d)(8)(B) of the Act, 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 shall 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.) However, if a "Lugar hospital" declines its redesignation as urban in order to retain its rural status, FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA from the chart to ensure correct payment under the capital PPS.

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

Hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)). The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the capital PPS. Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under §412.103 is determined from the applicable statewide rural wage index.

Medicare-Dependent Hospitals (MDHs): Budget Neutrality Adjustment Factors for FY 2002-Based Hospital-Specific (HSP) Rate

Effective FY 2010, we are correcting the MDH FY 2002 HSP rate calculation to include the cumulative budget neutrality adjustment factor for FYs 1993 through 2002 in addition to the budget neutrality adjustment factors for FYs 2003 forward. Section 5003(b) of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) allows MDHs to rebase their HSP rates using data from their FY 2002 cost report if this results in a payment increase. To implement this provision, CMS issued Transmittal 1067 (Change Request 5276 dated September 25, 2006) with instructions to FIs to determine and update the FY 2002 HSP rate for qualifying MDHs. To calculate an MDH's FY 2002 HSP rate and update it to FY 2007, the instructions directed FIs to apply cumulative budget neutrality adjustment factors for FYs 2003 through 2007. However, the instructions did not include the cumulative budget neutrality adjustment factor to account for changes in the DRGs from FYs 1993 through 2002.

To correct for this, FIs and A/B MACs shall adjust any FY 2002 HSP rates of MDHs currently in the Provider Specific File (PSF) by applying a factor of 0.982557, which is calculated as the product of the following budget neutrality adjustment factors from FYs 1993 through 2002: 0.999851 for FY 1993; 0.999003 for FY 1994; 0.998050 for FY 1995; 0.999306 for FY 1996; 0.998703 for FY 1997; 0.997731 for FY 1998; 0.998978 for FY 1999; 0.997808 for FY 2000; 0.997174 for FY 2001; and 0.995821 for FY 2002. This revised FY 2002 HSP rate shall be entered into the PSF with an effective date of October 1, 2009. (For FY 2010, the HSP rates in the PSF will continue to be entered in FY 2007 dollars.) In addition, FIs and A/B MACs shall confirm that

the correct inflation update from FYs 2002 through 2007 and the cumulative budget neutrality adjustment factors for FYs 2003 through 2007 of 1.169637383 was applied in the determination of the FY 2002-based HSP rate currently in the PSF. The factor of 1.169637383 is computed as the product of the FY 2003 update factor of 1.0295, the FY 2003 budget neutrality factor of 0.993111, the FY 2004 update factor of 1.034, the FY 2004 budget neutrality factor of 1.002608, the FY 2005 update factor of 1.033, the FY 2005 budget neutrality of 0.999876, the FY 2006 update factor of 1.037, the FY 2006 budget neutrality factor of 0.998993, the FY 2007 update factor of 1.034, and the FY 2007 budget neutrality factor of 0.997395.

Section 1886(d)(5)(G) of the Act provides that the HSP rate for MDHs is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever of these HSP rates is the highest. After the FY 2002 HSP rates are adjusted as described above, FIs and A/B MACS shall verify that the FY 2002 HSP rate is still the highest of the applicable based years (that is, FY 1982, FY 1987 or FY 2002). In those cases where a MDH's FY 2002 HSP rate is no longer higher than its FY 1982 or FY 1987 HSP rate, the applicable HSP rate (FY 1982 or FY 1987) updated to FY 2007 dollars shall be entered in to the PSF effective October 1, 2009. For FY 1982 or FY 1987 HSP rates that had previously been updated to FY 2000 dollars (that is, a MDH's HSP rate prior to the implementation of the rebasing to FY 2002 provided for by section 5003(b) of the DRA) before entering it in the PSF with an effective date of October 1, 2009, the FY 1982 or FY 1987 HSP shall be updated from FY 2000 dollars to FY 2007 dollars by applying an update factor of 1.233973509, which is computed as the product of the FY 2001 update factor of 1.034, the FY 2001 budget neutrality factor of 0.997174, the FY 2002 update factor of 1.0275, the FY 2002 budget neutrality factor of 0.995821 and the update and inflation factors for FYs 2003 through 2007 listed above.

As directed above, FIs and A/B MACs shall adjust the FY 2002 HSP rates of MDHs currently in the PSF and enter it that amount in the PSF with an effective date of October 1, 2009. This adjustment to the FY 2002 HSP rates of MDHs is not to be applied in determining payments for discharges occurring prior to October 1, 2009. For purposes of the settlement of MDH cost reports that include discharges that occurred from October 1, 2006 through September 30, 2009, FIs and A/B MACs shall use the originally computed, that is, the FY 2002 HSP rates of MDHs that is currently in the PSF.

The Long-Term Care Hospital (LTCH) PPS RY 2010 Update

RY 2010 LTCH PPS Rates

Federal Rate	$39,896.65
High Cost Outlier Fixed-Loss Amount	$18,425.00
Labor Share	75.779%
Non-Labor Share	24.221%

MS-LTC-DRG Update

The LTCH PPS Pricer has been updated with the Version 27.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010.

Provider Specific File (PSF)

The PSF required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update the all applicable fields for LTCHs effective October 1, 2009, or effective with cost reporting periods that begin on or after October 1, 2009, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8C of section VI of the addendum to the PPS final rule contain the RY 2010 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific total CCR from the latest settled or tentatively settled cost report. The LTCH total CCR ceiling for RY 2010 is 1.232.

Cost of Living Adjustment (COLA) Update for LTCH PPS

LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. See the table below for the updated COLAs implemented as part of the RY 2010 LTCH PPS Final Rule, which are effective for discharges occurring on or after October 1, 2009.

Area	COLA Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change from RY 2009)
Hawaii:	
City and County of Honolulu	1.25 (no change from RY 2009)
County of Hawaii	1.18
County of Kauai	1.25 (no change from RY 2009)
County of Maui and County of Kalawao	1.25 (no change from RY 2009)

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

There are several revisions to the Core-Based Statistical Area (CBSA)-based labor market definitions used under the LTCH PPS, which are the basis of the wage index adjustment, effective October 1, 2009. The following changes affect the CBSA codes used for the wage index assignment under the LTCH PPS:

(1) For any LTCHs currently located in CBSA 42260, the CBSA code on the PSF will need to be changed to 14660 (from 42260) effective October 1, 2009, due to a title change for that CBSA.

(2) For any LTCHs currently located in Bollinger County or Cape Girardeau County, Missouri, the CBSA code on the PSF will need to be changed to 16020 (from the rural 2-digit State code 26) effective October 1, 2009, due to the creation of a new urban CBSA.

(3) For any LTCHs currently located in Alexander County, Illinois, the CBSA code on the PSF will need to be changed to 16020 (from the rural 2-digit State code 14) effective October 1, 2009, due to the creation of a new urban CBSA.

(4) For any LTCHs currently located in Geary County, Pottawatomie County or Riley County, Kansas, the CBSA code on the PSF will need to be changed to 31740 (from the rural 2-digit State code 17) effective October 1, 2009, due to the creation of a new urban CBSA.

(5) For any LTCHs currently located in Blue Earth County or Nicollet County, Minnesota, the CBSA code on the PSF will need to be changed to 31860 (from the rural 2-digit State code 24) effective October 1, 2009, due to the creation of a new urban CBSA.

Changes to LTCH PPS Payment Policy made by the American Recovery and Reinvestment Act (ARRA) of 2009

The February 17, 2009 enactment of the ARRA, made changes to two provisions of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007, the 3-year moratoria on the establishment of new LTCHs and LTCH satellites and on the increase in beds in existing LTCHs and LTCH satellites and revisions to the percentage threshold payment adjustment for LTCHs and LTCH satellites. (These MMSEA changes, which were finalized in the RY 2010 LTCH PPS final rule, were addressed, respectively, in CR 6172, issued on December 19, 2008, and CR 5955, issued on March 7, 2008.) The ARRA added an additional exception to the moratorium on the increase in beds in existing LTCHs or LTCH satellites if an existing LTCH located in a State that required a Certificate of Need (CON), had obtained a CON for a bed increase that was issued on or after April 1, 2005 and before December 29, 2007. Additionally, the ARRA amended the MMSEA provision regarding the percentage threshold payment adjustment. (These ARRA changes were implemented in an interim final rule with comment period which was published with the RY 2010 LTCH PPS final rule.) Specifically, an additional category of LTCH satellites, "grandfathered" satellites (described at 42 CFR §412.22(h)(3)(i)) was added to those LTCH HwHs and satellites identified by the MMSEA as "applicable" for the 3-year percentage threshold increase. The ARRA also changed the effective date of all of MMSEA changes from the effective date of MMSEA (December 29, 2009) to July 1, 2007 or October 1, 2007, based upon the particular provision.

Specific instructions for Medicare Contractors on the ARRA provisions have been issued in a One-Time Notification, Pub 100-20 Transmittal 466, issued on March 27, 2009, and in a Memorandum, S&C-09-32, issued on April 17, 2009.

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 all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our 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 2010 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 2010 **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.

Diagnosis Code	Description	MS-DRG
438.13	Late effects of cerebrovascular disease, dysarthria	056, 057
438.14	Late effects of cerebrovascular disease, fluency disorder	056, 057
799.21	Nervousness	880
799.22	Irritability	880
799.23	Impulsiveness	882
799.24	Emotional lability	883
799.25	Demoralization and apathy	880
799.29	Other signs and symptoms involving emotional state	880

The following table lists the FY 2010 **invalid** ICD-9-CM diagnosis code that is no longer applicable for the DRG adjustment.

Diagnosis Code	Description	MS-DRG
799.2	Nervousness	880

Since we do not plan to update the regression analysis until we analyze IPF PPS data, the MS-DRG adjustment factors, shown in Pub. 100-04, Chapter 3, Section 190.5.1 are effective October 1, 2009, and will continue to be paid for RY 2010.

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 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 utilizes 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. We are currently using the FY 2010 GROUPER, Version 27.0 which is effective for discharges occurring on or after October 1, 2009.

The following three tables below list the FY 2010 new, revised and invalid ICD-9-CM diagnosis codes, 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 2010 changes, and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

The table below lists the FY 2010 **new** ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table lists only the FY 2010 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2010 IPF Pricer will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis Code	Description	Comorbidity Category
209.31	Merkel cell carcinoma of the face	Oncology Treatment
209.32	Merkel cell carcinoma of the scalp and neck	Oncology Treatment
209.33	Merkel cell carcinoma of the upper limb	Oncology Treatment
209.34	Merkel cell carcinoma of the lower limb	Oncology Treatment
209.35	Merkel cell carcinoma of the trunk	Oncology Treatment
209.36	Merkel cell carcinoma of other sites	Oncology Treatment
209.70	Secondary neuroendocrine tumor, unspecified site	Oncology Treatment
209.71	Secondary neuroendocrine tumor of distant lymph nodes	Oncology Treatment
209.72	Secondary neuroendocrine tumor of liver	Oncology Treatment

209.73	Secondary neuroendocrine tumor of bone	Oncology Treatment
209.74	Secondary neuroendocrine tumor of peritoneum	Oncology Treatment
209.75	Secondary Merkel cell carcinoma	Oncology Treatment
209.79	Secondary neuroendocrine tumor of other sites	Oncology Treatment
239.81	Neoplasms of unspecified nature, retina and choroid	Oncology Treatment
239.89	Neoplasms of unspecified nature, other specified sites	Oncology Treatment
969.00	Poisoning by antidepressant, unspecified	Poisoning
969.01	Poisoning by monoamine oxidase inhibitors	Poisoning
969.02	Poisoning by selective serotonin and norepinephrine reuptake inhibitors	Poisoning
969.03	Poisoning by selective serotonin reuptake inhibitors	Poisoning
969.04	Poisoning by tetracyclic antidepressants	Poisoning
969.05	Poisoning by tricyclic antidepressants	Poisoning
969.09	Poisoning by other antidepressants	Poisoning
969.70	Poisoning by psychostimulant, unspecified	Poisoning
969.71	Poisoning by caffeine	Poisoning
969.72	Poisoning by amphetamines	Poisoning
969.73	Poisoning by methylphenidate	Poisoning
969.79	Poisoning by other psychostimulants	Poisoning

The table below lists the FY 2010 **revised** ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2010 revised codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

Diagnosis Code	Description	Comorbidity Category
584.5	Acute kidney failure with lesion of tubular necrosis	Renal Failure, Acute
584.6	Acute kidney failure with lesion of renal cortical necrosis	Renal Failure, Acute
584.7	Acute kidney failure with lesion of renal medullary [papillary] necrosis	Renal Failure, Acute
584.8	Acute kidney failure with other specified pathological lesion in kidney	Renal Failure, Acute
584.9	Acute kidney failure, unspecified	Renal Failure, Acute
639.3	Kidney failure following abortion and ectopic and molar pregnancies	Renal Failure, Acute
669.32	Acute kidney failure following labor and delivery, delivered, with mention of postpartum complication	Renal Failure, Acute
669.34	Acute kidney failure following labor and delivery, postpartum condition or complication	Renal Failure, Acute

The table below lists the **invalid** ICD-9-CM codes no longer applicable for the comorbidity adjustment. The RY 2010 IPF Pricer will be updated to remove these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis Code	Description	Comorbidity Category
239.8	Neoplasm of unspecified nature of other specified sites	Oncology Treatment
969.0	Poisoning by antidepressants	Poisoning
969.7	Poisoning by psychostimulants	Poisoning

The table below lists the seventeen comorbidity categories for which we are providing an adjustment, their respective codes, including the new FY 2010 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
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
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

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6634.1	FISS shall install and pay claims with the FY 2010 IPPS Pricer for discharges on or after October 1, 2009**.**						X				
6634.2	FISS shall install and pay claims with the FY 2010 LTCH Pricer for discharges on or after October 1, 2009.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6634.3	FISS shall install and pay claims with the ICD-9 update to the RY 2010 IPF Pricer for discharges on or after October 1, 2009.						X				
6634.4	FISS shall install and edit claims with the MCE version 26.0 and GROUPER version 27.0 software with the implementation of the FY 2010 October quarterly release.						X				
6634.4.1	FISS shall create associated reason codes for the newly created MCE edit #18 – Wrong Procedure Performed.						X				
6634.4.1.1	Contractors shall set the disposition of reason code(s) associated with MCE edit #18 to suspend (in order for contractors to add claim information to the erroneous surgery tracking list, per CR 6405).	X		X							
6634.4.1.1.1	Once claim data is added to the surgical errors list, contractors shall continue to process the suspended claim by overriding the MCE.	X		X							
6634.4.1.2	FISS shall modify reason code 36459 (created with CR 6405) to add diagnosis codes E.876.5, E876.6, and E876.7 to the reason code logic effective for discharges 10/1/2009 and greater.						X				
6634.4.1.3	Contractors shall deny claims receiving MCE edit # 18.	X		X							
6634.5	CWF shall update edit 7272 with the postacute care DRGs listed in Table 5 of the IPPS Final Rule for discharges on or after October 1, 2009 (includes special pay).									X	
6634.6	Contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X		X							
6634.7	Contractors shall update relevant portions of the provider specific file in accordance with this CR.	X		X							
6634.8	Contractors shall be aware of the manual updates included within this CR.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6634.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirement:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6634.4.1.1	Reason Code 31737 will edit if an e-code is present in the principal diagnosis position.
6634.4.1.1	MCE reason codes W1602, W1603, W1604, W1605, W1606, W1607, W1608, W1609 or W1610 will edit if one of the e-codes is present.
6634.4.1.1	Contractors shall not report such overrides on their monthly reports described in Chapter 3, Section 20.2.1.1.2.
6634.4.1.3	Contractors shall utilize a MPP and/or ECPS to deny claims.
6634.4.1.3	Contractors shall deny claims/lines using the following: Medicare Summary Notice: **23.17** – Medicare won't cover these services because they are not considered medically necessary." **23.17** – Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas.Claim Adjustment Reason Code: **50** – These are non-covered services because this is not deemed a 'medical necessity" by the payer Group Code: **CO** – Contractual Obligation

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Sarah Shirey-Losso at sarh.shirey-losso@cms.hhs.gov or 410-786-0187
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Valeri Ritter at valeri.ritter@cms.hhs.gov or 410-786-8652

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachments

Attachment A: Rural Floor Budget Neutrality Factors for Acute Care Hospitals – FY 2010

The rural floor budget neutrality adjustment factor in this table reflects a blend of the State factor (weighted at 50 percent) and the nationwide factor (50 percent).

State	Rural Floor Budget Neutrality Adjustment Factor
Alabama	0.99835
Alaska	0.99835
Arizona	0.99835
Arkansas	0.99835
California	0.99415
Colorado	0.99413
Connecticut	0.97887
Delaware	0.99835
Washington, D.C.	0.99835
Florida	0.99755
Georgia	0.99835
Hawaii	0.99835
Idaho	0.99835
Illinois	0.99835
Indiana	0.99813
Iowa	0.99767
Kansas	0.99829
Kentucky	0.99835
Louisiana	0.99835
Maine	0.99835
Maryland	------
Massachusetts	0.99835
Michigan	0.99835
Minnesota	0.99835
Mississippi	0.99835
Missouri	0.99835
Montana	0.99835
Nebraska	0.99835
Nevada	0.99835
New Hampshire	0.99698
New Jersey **	0.98437
New Mexico	0.99576
New York	0.99836
North Carolina	0.99833
North Dakota	0.99668
Ohio	0.99783
Oklahoma	0.99835
Oregon	0.99705
Pennsylvania	0.99812
Puerto Rico	0.99835
Rhode Island	0.99835

State	Rural Floor Budget Neutrality Adjustment Factor
South Carolina	0.99778
South Dakota	0.99835
Tennessee	0.99691
Texas	0.99835
Utah	0.99835
Vermont	0.99835
Virginia	0.99835
Washington	0.99792
West Virginia	0.99714
Wisconsin	0.99816
Wyoming	0.99835

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS ratesetting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see TABLE 4B).

Attachment B: Section 505 Adjustment: Provider Numbers and Corresponding Special Wage Indexes

010008	0.7563
010015	0.7435
010021	0.7441
010027	0.7415
010032	0.7714
010038	0.7650
010040	0.8411
010045	0.7611
010046	0.8411
010047	0.7516
010049	0.7415
010078	0.7650
010091	0.7435
010109	0.7794
010110	0.7604
010125	0.7865
010128	0.7435
010129	0.7523
010138	0.7455
010146	0.7650
010150	0.7516
030067	0.9099
040047	0.7676
040067	0.7566
040081	0.7916
040149	0.7758
050007	1.5600
050070	1.5600
050090	1.5541
050113	1.5600
050118	1.2377
050122	1.2377
050136	1.5541
050167	1.2377
050174	1.5541
050289	1.5600
050291	1.5541
050298	1.1756
050313	1.2377
050325	1.1778
050336	1.2377
050366	1.1760
050385	1.5541
050444	1.2086
050547	1.5541
050690	1.5541
050748	1.2377
050754	1.5600
080001	1.0786
080003	1.0786
090001	1.0733
090003	1.0733
090005	1.0733
090006	1.0733
090008	1.0733
100290	0.8932
110100	0.8609
110101	0.7886
110142	0.8004
110190	0.8060
110205	0.8326
130024	0.8318
130066	0.9380
140001	0.8691
140026	0.8637
140116	1.0399
140176	1.0399
140234	0.8637
150022	0.8671
150072	0.8618
160013	0.8743
160030	0.9546
160032	0.8799
170150	0.8349
180064	0.8275
180070	0.8201
180079	0.8220
190034	0.8013
190044	0.8085
190050	0.7868
190053	0.7925
190054	0.7909
190078	0.8011
190099	0.8013
190116	0.7909
190133	0.7926
190140	0.7859
190145	0.7914
190246	0.7899
200032	0.8922
230005	0.9270
230015	0.9092
230041	0.9498
230047	0.9879
230075	1.0121
230093	0.8855
230099	1.0193
230204	0.9879
230217	1.0121
230227	0.9879
230257	0.9879
230264	0.9879
230301	0.9883
240018	1.0071
240044	0.9891
240117	0.9793
240211	1.0078
250128	0.8163
250162	0.8737
260059	0.8241
260097	0.8464
260160	0.8308
260163	0.8251
320011	0.9301
320018	0.8988
320085	0.8988
320088	0.8988
330010	0.8541
330033	0.8697
330047	0.8541
330103	0.8605
330106	1.2841
330132	0.8605
330135	1.1908
330144	0.8530
330151	0.8530
330175	0.8734
330205	1.1908
330264	1.1908
330276	0.8510
340020	0.8749
340024	0.8770

340037	0.8755
340038	0.8846
340068	0.8680
340070	0.9042
340104	0.8755
340133	0.8853
340151	0.8645
360002	0.8656
360040	0.8902
360044	0.8642
360070	0.8666
360071	0.8550
360084	0.8666
360096	0.8586
360107	0.8634
360131	0.8666
360151	0.8666
360156	0.8634
360161	0.8673
370023	0.7897
370065	0.7903
370072	0.8065
370083	0.7858
370100	0.7907
370156	0.7928
370169	0.7970
370172	1.4682
370214	0.7928
390008	0.8423
390039	0.8400
390052	0.8410
390056	0.8399
390112	0.8400
390117	0.8365
390122	0.8416
390125	0.8385
390146	0.8385
390150	0.8394
390173	0.8400
390201	0.9533
390236	0.8366
390316	0.9403
420002	0.9316
420019	0.8547
420043	0.8546
420053	0.8424
420054	0.8391
420082	0.9442
430008	0.8895
430048	0.8489
430094	0.8489
440007	0.8109
440008	0.8339
440012	0.8120
440016	0.8034
440017	0.8120
440031	0.7909
440033	0.7917
440047	0.8228
440050	0.7899
440051	0.7972
440057	0.7911
440060	0.8228
440063	0.7923
440070	0.7999
440081	0.7942
440084	0.7915
440105	0.7923
440109	0.7960
440115	0.8228
440137	0.8628
440176	0.8120
440180	0.7917
440181	0.8255
440182	0.8034
440184	0.7923
450052	0.7944
450059	0.8988
450090	0.8594
450163	0.7998
450192	0.8215
450194	0.8157
450210	0.8095
450236	0.8333
450270	0.8215
450395	0.8385
450451	0.8480
450460	0.7997
450497	0.8319
450539	0.8011
450573	0.8070
450615	0.7977
450641	0.8319
450698	0.8071
450755	0.8220
450813	0.8070
450838	0.8070
450884	0.8288
450888	0.9458
460001	0.9444
460013	0.9444
460017	0.8825
460023	0.9444
460043	0.9444
460052	0.9444
490002	0.8104
490038	0.8104
490084	0.8288
490105	0.8104
490110	0.8534
500019	1.0250
510012	0.7594
520035	0.9334
520044	0.9334
520045	0.9248
520048	0.9248
520057	0.9419
520198	0.9248

Attachment C: Hospital Quality Initiative

State	HSP ID	Hospital Name
AL	010015	SOUTHWEST ALABAMA MEDICAL CENTER
AL	010052	LAKE MARTIN COMMUNITY HOSPITAL
AZ	030074	SELLS INDIAN HEALTH SERVICE HOSPITAL
AZ	030113	WHITERIVER PHS INDIAN HOSPITAL
CA	050091	COMMUNITY AND MISSION HOSPITAL OF HUNTINGTON PARK
CA	050110	LOMPOC VALLEY MEDICAL CENTER
CA	050193	SOUTH COAST MEDICAL CENTER
CA	050205	EAST VALLEY HOSPITAL MEDICAL CENTER
CA	050301	UKIAH VALLEY MEDICAL CENTER/HOSPITAL D
CA	050325	TUOLUMNE GENERAL MEDICAL FACILITY
CA	050342	PIONEERS MEMORIAL HEALTHCARE DISTRICT
CA	050378	PACIFICA HOSPITAL OF THE VALLEY
CA	050385	PALM DRIVE HOSPITAL
CA	050423	PALO VERDE HOSPITAL
CA	050433	INDIAN VALLEY HOSPITAL
CA	050545	LANTERMAN DEVELOPMENTAL CENTER
CA	050546	PORTERVILLE DEVELOPMENTAL CENTER
CA	050548	FAIRVIEW DEVELOPMENTAL CENTER
CA	050662	AGNEWS STATE HOSPITAL
CA	050667	N M HOLDERMAN MEMORIAL HOSPITAL
CA	050682	KINGSBURG MEDICAL CENTER
CA	050698	SAN DIEGO HOSPICE & THE INSTITUTE FOR PALLIATIVE MEDICINE
CA	050740	MARINA DEL REY HOSPITAL
CA	050751	MIRACLE MILE MEDICAL CENTER
CA	050760	KAISER FOUNDATION HOSPITAL - ANTIOCH
CO	060049	YAMPA VALLEY MEDICAL CENTER
CT	070038	CONNECTICUT HOSPICE INC.

FL	100105	INDIAN RIVER MEMORIAL HOSPITAL INC
FL	100134	ED FRASER MEMORIAL HOSPITAL
FL	100139	NATURE COAST REGIONAL HOSPITAL
FL	100298	FLORIDA STATE HOSPITAL UNIT 31 MED
HI	120004	WAHIAWA GENERAL HOSPITAL
ID	130062	IDAHO FALLS RECOVERY CENTER
IL	140033	VISTA MEDICAL CENTER WEST
IL	140082	VHS ACQUISTION DBA LOUIS A WEISS MEMORIAL HOSPITAL
IL	140151	SACRED HEART HOSPITAL
IL	140205	SWEDISH AMERICAN MEDICAL CENTER BELVIDERE
IN	150166	PINNACLE HOSPITAL
KS	170180	MEADOWBROOK REHABILITATION HOSPITAL
LA	190037	SOUTH CAMERON MEMORIAL HOSPITAL
LA	190118	DESOTO REGIONAL HEALTH SYSTEM
LA	190161	W O MOSS REGIONAL MEDICAL CENTER
LA	190208	EAST CARROLL PARISH HOSPITAL
LA	190245	MONROE SURGICAL HOSPITAL
LA	190297	DOCTORS HOSPITAL AT DEER CREEK LLC
MA	220153	SOLDIERS HOME OF HOLYOKE
MA	220154	CHELSEA SOLDIERS HOME
MA	220172	UNIVERSITY HEALTH SERVICES
MA	220177	NANTUCKET COTTAGE HOSPITAL
MI	230135	HENRY FORD COTTAGE HOSPITAL
MI	230144	FOREST HEALTH MEDICAL CENTER
MN	240196	PHILLIPS EYE INSTITUTE
MS	250018	JASPER GENERAL HOSPITAL
MS	250060	JEFFERSON COUNTY HOSPITAL
MS	250079	SHARKEY ISSAQUENA COMMUNITY HOSPITAL
MS	250127	CHOCTAW HEALTH CENTER
MS	250149	NEWTON REGIONAL HOSPITAL
MS	250151	ALLIANCE HEALTH CENTER
MS	250152	MISSISSIPPI METHODIST REHAB CTR
MO	260104	SSM DEPAUL HEALTH CENTER
NE	280119	P H S INDIAN HOSPITAL

NV	290002	SOUTH LYON MEDICAL CENTER
NV	290020	NYE REGIONAL MEDICAL CENTER
NV	290027	GROVER C DILS MEDICAL CENTER
NV	290042	HARMON MEDICAL AND REHABILITATION HOSPITAL
NM	320057	SANTA FE PHS INDIAN HOSPITAL
NY	330010	AMSTERDAM MEMORIAL HEALTH CARE SYSTEM
NY	330407	EDDY COHOES REHABILITATION CENTER
NY	330408	TRI-TOWN REGIONAL HEALTHCARE
NC	340104	CRAWLEY MEMORIAL HOSPITAL
NC	340138	CENTRAL REGIONAL HOSPITAL
NC	340168	WILMINGTON TREATMENT CENTER
OH	360046	MCCULLOUGH-HYDE MEMORIAL HOSPITAL
OH	360241	EDWIN SHAW REHAB, LLC
OH	360247	WOODS AT PARKSIDE,THE
OH	360258	BARIX CLINICS OF OHIO, LLC
OH	360349	ADVANCED SPECIALTY HOSPITAL OF TOLEDO
OK	370011	PARKVIEW HOSPITAL
OK	370214	LINDSAY MUNICIPAL HOSPITAL
OK	370220	ORTHOPEDIC HOSPITAL
PA	390104	KANE COMMUNITY HOSPITAL
PA	390302	BARIX CLINICS OF PENNSYLVANIA
SD	430060	HOLY INFANT HOSPITAL
SD	430081	PINE RIDGE IHS HOSPITAL
SD	430083	PHS INDIAN HOSPITAL AT EAGLE BUTTE
SD	430084	ROSEBUD IHS HOSPITAL
SD	430093	SAME DAY SURGERY CENTER LLC
SD	430096	LEWIS AND CLARK SPECIALTY HOSPITAL
TN	440007	UNITED REGIONAL MEDICAL CENTER
TN	440026	ROLLING HILLS NASHVILLE REHAB HOSPITAL
TN	440147	BAPTIST REHABILITATION GERMANTOWN
TN	440162	HEALTHSOUTH CHATTANOOGA REHAB HOSPITAL
TN	440181	BOLIVAR GENERAL HOSPITAL
TN	440218	THE CENTER FOR SPINAL SURGERY
TX	450044	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL - ST. PAUL

TX	450253	BELLVILLE GENERAL HOSPITAL
TX	450283	COZBY-GERMANY HOSPITAL
TX	450446	RIVERSIDE GENERAL HOSPITAL
TX	450460	TYLER COUNTY HOSPITAL
TX	450683	RENAISSANCE HOSPITAL TERRELL
TX	450749	EAST TEXAS MEDICAL CENTER TRINITY
TX	450766	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL - ZALE LIPSHY
TX	450770	CENTRAL TEXAS HOSPITAL
TX	450796	NORTHWEST TEXAS SURGERY CENTER
TX	450813	COMMUNITY GENERAL HOSPITAL
TX	450831	SURGERY SPECIALTY HOSPITALS OF AMERICA
TX	450839	SHELBY REGIONAL MEDICAL CENTER
TX	450845	EL PASO SPECIALTY HOSPITAL
UT	460018	KANE COUNTY HOSPITAL
UT	460035	BEAVER VALLEY HOSPITAL
VA	490002	RUSSELL COUNTY MEDICAL CENTER
VA	490104	HIRAM W DAVIS MEDICAL CENTER
VA	490105	SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
VA	490108	CENTRAL VIRGINIA TRAINING CENTER
VA	490129	CAPITAL HOSPICE - HALQUIST MEMORIAL INPATIENT CENTER
VA	490134	PIEDMONT GERIATRIC HOSPITAL
VA	490135	CATAWBA HOSPITAL
WY	530017	SOUTH LINCOLN MEDICAL CENTER
TX	670007	BEAUMONT BONE & JOINT INSTITUTE
TX	670008	HOUSTON PHYSICIANS' HOSPITAL
TX	670010	DENTON REHABILITATION HOSPITAL L.P.
TX	670021	INNOVA HOSPITAL SAN ANTONIO
TX	670027	ACUITY HOSPITAL OF HOUSTON
TX	670029	FIRST STREET HOSPITAL LP
TX	670040	ATRIUM MEDICAL CENTER
TX	670045	COOK CHILDRENS NORTHEAST HOSPITAL, L.L.C.
TX	670050	TRUSTPOINT HOSPITAL

Attachment D: Wage Index Changes

Wage index values have changed for the following areas per the FY 2010 correction notice. NOTE: These wage index values DO NOT have the state specific blended rural floor budget neutrality factors applied. The state specific rural floor budget neutrality factors are published in Attachment A for this CR.

Record	CBSA	Area WIX	Reclass WIX	CBSA Name
New	05	**1.1901**	**1.1901**	CALIFORNIA
Old	05	**1.1814**	**1.1814**	CALIFORNIA
New	10900	1.1521	**0.9829**	Allentown-Bethlehem-Easton, PA-NJ
Old	10900	1.1521	**0.9654**	Allentown-Bethlehem-Easton, PA-NJ
New	12540	**1.1901**	0	Bakersfield, CA
Old	12540	**1.1814**	0	Bakersfield, CA
New	15380	**0.9825**	**0.9825**	Buffalo-Niagara Falls, NY
Old	15380	**0.9816**	**0.9816**	Buffalo-Niagara Falls, NY
New	17020	**1.1901**	0	Chico, CA
Old	17020	**1.1814**	0	Chico, CA
New	19804	**0.9793**	**0**	Detroit-Livonia-Dearborn, MI
Old	19804	**0.9804**	**0.9804**	Detroit-Livonia-Dearborn, MI
New	20940	**1.1901**	0	El Centro, CA
Old	20940	**1.1814**	0	El Centro, CA
New	23420	**1.1901**	0	Fresno, CA
Old	23420	**1.1814**	0	Fresno, CA
New	23844	**0.9185**	**0.9185**	Gary, IN
Old	23844	**0.9213**	**0.9213**	Gary, IN
New	25260	**1.1901**	0	Hanford-Corcoran, CA
Old	25260	**1.1814**	0	Hanford-Corcoran, CA
New	31084	1.196	**1.1901**	Los Angeles-Long Beach-Santa Ana, CA
Old	31084	1.196	**1.1835**	Los Angeles-Long Beach-Santa Ana, CA
New	31460	**1.1901**	0	Madera-Chowchilla, CA
Old	31460	**1.1814**	0	Madera-Chowchilla, CA

New	33700	1.241	**1.2274**	Modesto, CA
Old	33700	1.241	**1.241**	Modesto, CA
New	40140	**1.1901**	1.1165	Riverside-San Bernardino-Ontario, CA
Old	40140	**1.1814**	1.1165	Riverside-San Bernardino-Ontario, CA
New	41740	**1.1901**	0	San Diego-Carlsbad-San Marcos, CA
Old	41740	**1.1814**	0	San Diego-Carlsbad-San Marcos, CA
New	42044	**1.1901**	**1.1901**	Santa Ana-Anaheim-Irvine, CA
Old	42044	**1.1814**	**1.1814**	Santa Ana-Anaheim-Irvine, CA
New	47300	**1.1901**	0	Visalia-Porterville, CA
Old	47300	**1.1814**	0	Visalia-Porterville, CA
New	49700	**1.1901**	0	Yuba City, CA
Old	49700	**1.1814**	0	Yuba City, CA

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 1816, 09-17-09)

20.3.1.3 – Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009

20.1 – Hospital Operating Payments Under PPS

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Under the PPS, Medicare payment for hospital inpatient operating costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the PPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the PPS are made on the basis of the standardized amounts, some categories of hospitals are paid *based on* the higher of a hospital-specific rate *determined from* their costs in a base year *as specified in the statute,* or the PPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and small rural Medicare-dependent hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although *the statutory payment formulas for SCHs and MDHs differ as described below in section 20.6).*

The existing regulations governing payments to hospitals under the PPS are located in 42 CFR Part 412, Subparts A through M.

20.1.2.3 - Threshold and Marginal Cost

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

The FI, using Pricer, determines an appropriate additional payment for inpatient services where hospital charges for covered services furnished to the beneficiary, adjusted for cost, are extraordinarily high. CMS annually determines, and includes in the annual IPPS Final Rule and in Pricer, the threshold beyond which a cost outlier is paid. The additional payment amount is the difference between the estimated cost for the discharge (determined by multiplying the hospital specific CCR by the hospital's charges for the discharge) and the threshold criteria established for the applicable DRG multiplied by a marginal cost factor of 80 percent. (The marginal cost factor for burn cases is 90 percent, as described in section 20.1.2.8.) CMS includes the marginal cost factor in Pricer. For more explanation on the calculation of outliers visit our Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*

20.2.1 - Medicare Code Editor (MCE)

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. General

The MCE edits claims to detect incorrect billing data. In determining the appropriate *Medicare Severity Diagnosis Related Group (MS-DRG)* for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software

assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a *MS*-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the *MS*-DRG assignment:

> **Code Edits -** Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.
>
> **Coverage Edits -** Examines the type of patient and procedures performed to determine if the services where covered.
>
> **Clinical Edits -** Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B. Implementation Requirements

The FI/*MAC* processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. Bill System/MCE Interface

The FI/*MAC* installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the bill:

- Age;
- Sex;
- Discharge status;
- Diagnosis (9 maximum – principal diagnosis and up to 8 additional diagnoses);
- Procedures (6 maximum); and
- Discharge date.

The MCE provides the FI/*MAC* an analysis of "errors" on the bill as described in subsection D. The FI/*MAC* develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the FI/*MAC* considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes*, see the most current list available on the National Center for Health Statistics (NCHS) Web site*. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI/*MAC* returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI/*MAC*. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. E-Code as Principal Diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses.

E-codes are *valid* ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), *see the most current list available on the National Center for Health Statistics (NCHS) Web site,* Volume l (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

3. Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity MS-DRG. Hospitals may not repeat a diagnosis code. The FI*/MAC* will delete the duplicate secondary diagnosis and process the bill.

4. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old *obstetrical* delivery.

In the above cases, the diagnosis is clinically *unlikely* in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The diagnoses described in the Medicare Code Editor, posted on the CMS Webpage at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10 are acceptable only for the age categories shown. If the FI*/MAC* edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI*/MAC* edits in batch operations after receipt of the admission query response, it uses the age

based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis or patient's age before returning the bill.

5. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The Medicare Code Editor contains listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, *diagnoses*, and procedure before returning the bill.

6. Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The Medicare Code Editor contains listings of ICD-9-CM diagnoses identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign *h*ypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

The Medicare Code Editor contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The *FI/MAC* may review on a post-payment basis all questionable admission cases. Where the *FI/MAC* determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, Vl73 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." The FI*/MAC* may review claims with *therapy* diagnosis V571, V5721, V5722, V573, V5789, and V579 and a secondary diagnosis. *The FI/MAC* may choose to review as a principal diagnosis if data analysis deems it a priority.

If these codes are identified without a secondary diagnosis, the FI*/MAC* returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment. The FI*/MAC* will return the bill requesting either:

- A no pay bill, or
- A correction in the procedure code.
- A bill indicating the covered and noncovered procedures.

If the hospital indicates that there are covered and noncovered procedures, the FI*/MAC* refers the bill to the QIO for prepayment review. Upon receipt of the QIOs response, it either deletes the noncovered procedures and charges or requires the hospital to delete

them. It does not process the noncovered procedures through Grouper or the noncovered charges through Pricer.

12. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The *MS*-DRG Grouper logic assign a patient to different *MS*-DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI/*MAC* requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the FI/*MAC* changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The FI/*MAC* assigns the appropriate closed biopsy code after reviewing the medical information.

13. Bilateral Procedure

There are codes that do not accurately reflect *procedures* performed in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The FI/*MAC* processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the FI/*MAC* may develop claims prior to payment on a provider-specific basis.

14. Invalid Age

If the hospital reports an age over l24, the FI/*MAC* requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

15. Invalid Sex

A patient's sex is sometimes necessary for appropriate *MS*-DRG determination. Usually the FI/*MAC* can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

***16*. Invalid Discharge Status**

A patient's discharge status is sometimes necessary for appropriate *MS*-DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

***17* – Limited Coverage**

Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The FI/*MAC* will handle these procedures as *done* previously.

18 – Wrong Procedure Performed

Effective October 1, 2009, the following E-codes, whether they are in the principal or secondary diagnosis position, will trigger the "Wrong Procedure Performed" edit. Any claim with these codes will get the edit and will get an ungroupable MS-DRG. Note: If these E codes are in the principal diagnosis position, two edits will trigger; the "E code as PDX" edit and the "Wrong Procedure Performed" edit.

E876.5	*Performance of wrong operation (procedure) on correct patient*
E876.6	*Performance of operation (procedure) on patient not scheduled for surgery*
E876.7	*Performance of correct operation (procedure) on wrong side/body part*

20.3.1.3 – Disproportionate Share Hospital (DSH) Policy Changes Effective for Cost Reporting Periods beginning on or after October 1, 2009

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Observation Days

For cost reporting periods beginning on or after October 1, 2009, observation days for patients later admitted as an inpatient will no longer be included in the Medicare disproportionate patient percentage (DPP). In addition, observation bed days for patients later admitted as an inpatient will no longer be counted towards a hospital's available bed day count for DSH and IME. Between October 1, 2003, and October 1, 2009, hospitals had reported on their cost report the Medicaid observation patient days for admitted patients and total observation patient days for admitted patients for inclusion in the Medicaid fraction of the Medicare DPP, and for the determination of the available bed day count for DSH and IME. However, effective for cost reporting periods

beginning on or after October 1, 2009, observation patient days are no longer included in the DPP, and observation bed days will no longer be counted towards the available bed day count for DSH or IME.

Labor and Delivery Patient Days

For cost reporting periods beginning on or after October 1, 2009, we will include in the Medicare disproportionate patient percentage (DPP) patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a "maternity suite" in which labor, delivery, recovery and postpartum care all take place in the same room. Prior to October 1, 2009, patient days associated with beds used for ancillary labor and deliver were not counted in the DPP. However, for cost reporting periods beginning on or after October 1, 2009, if a patient, admitted to the hospital as an inpatient, occupies an ancillary bed for labor and delivery, the patient days associated with the ancillary labor/delivery services will be counted in the DPP. This policy applies only to counting patient days, and does not change the policy of determining the number of available beds in 42 CFR 412.106(a). Beds associated with ancillary labor/delivery services are not included in the available bed day count.

Reporting Inpatient Days in the Numerator of the Medicaid Fraction

Hospitals can report days in the numerator of the Medicaid fraction by one of three methodologies. For cost reporting periods beginning on or after October 1, 2009, hospitals can report Medicaid-eligible days based on date of discharge, date of admission, or dates of service. A hospital is required to notify CMS (through the fiscal intermediary or MAC) in writing if the hospital chooses to change its methodology of counting days in the numerator of the Medicaid fraction. The written notification should be submitted at least 30 days prior to the beginning of the cost reporting period to which the change would apply. The written notification must specify the changed methodology the hospital wishes to use and the cost reporting period for which the methodology would apply. The change in methodology would be effective on the first day of the specified cost reporting period for the entire cost reporting period. The change would be effective for all future cost reporting periods unless the hospital submits a subsequent written notification to change its methodology.

20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. Criteria for Sole Community Hospitals (SCHs)

A sole community hospital (SCH) is a hospital that is paid under the Medicare hospital inpatient prospective payment system (IPPS) and is either located more than 35 miles from other like hospitals or is located in a rural area, and meets the criteria for SCH status as specified at 42 CFR 412.92 (Title 42 of the Code of Federal Regulations,

Section 412.92, Special treatment: Sole community hospitals). A hospital may be designated as an SCH effective with cost reporting periods beginning on or after October 1, 1990.

B. Criteria for Medicare Dependent Hospitals (MDHs)

A Medicare-dependent, small rural hospital (MDH) is a hospital that is paid under the Medicare hospital inpatient prospective payment system (IPPS) and meets the criteria for MDH status as specified at 42 CFR 412.108 (Title 42 of the Code of Federal Regulations, Section 412.108 Special treatment: Medicare-dependent, small rural hospitals). A hospital may be designated as an MDH effective with cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993, and for discharges occurring on or after October 1, 1997, and before October 1, 2011.

C. Payment to SCHs and MDHs

SCHs and MDHs are paid based on either the Federal rate or their hospital-specific (HSP) rate, whichever will result in the greatest payment. The HSP rate is the hospital's rate based on their updated costs per discharge for a particular fiscal year (FY) as specified in statute. Like all IPPS hospitals paid, SCHs and MDHs are paid for their discharges based on the diagnosis-related DRG classification and weights regardless of whether payment based on the Federal rate or the hospital's HSP rate results in the greatest payment.

SCHs will be paid based on their HSP rate for either FY 1982, 1987, 1996 (for cost reporting periods beginning on or after October 1, 2000) or 2006 (for cost reporting periods beginning on or after January 1, 2009) if this results in a greater payment than the Federal rate. For more detail, see 42 CFR 412.92(d) and 42 CFR 412.73, 412.75, 412.77, and 412.78, respectively, for determining the HSP rates for FYs 1982, 1987, 1996 and 2006.

MDHs will be paid based on their HSP rate for either FY 1982, 1987, or 2002 (for cost reporting periods beginning on or after October 1, 2006) if this results in a greater payment than the Federal rate. For more detail, see 42 CFR 412.108(c) and 42 CFR 412.73, 412.75, and 412.79, respectively, for determining the HSP rates for FYs 1982, 1987, and 2002.

In addition, qualifying SCHs and MDHs that experience a significant decrease in its number of discharges may receive an additional payment as specified at 42 CFR 412.92(e) and 42 CFR 412.108(d), respectively.

In general, the HSP rates for both SCHs and MDHs are updated annually. The HSP rates are updated for inflation by the applicable market basket increase for each FY after the base period year, and are also adjusted by a budget neutrality factor to account for the annual DRG reclassification and recalibration for each year from FY 1993 forward, regardless of the year of the base period. (For reference purposes, the budget neutrality

adjustment factors are listed below at the end of this section.) For the inflation update, beginning FY 2005, if the hospital did not submit quality data, the market basket update is reduced by a percentage specified in statute for the applicable FY consistent with section 1886(b)(3)(B)(viii) of the Act.

Applicable Fiscal Year	Budget Neutrality Adjustment Factors
1993	0.999851
1994	0.999003
1995	0.998050
1996	0.999306
1997	0.998703
1998	0.997731
1999	0.998978
2000	0.997808
2001	0.997174
2002	0.995821
2003	0.993111
2004	1.002608
2005	0.999876
2006	0.998993
2007	0.997395
2008	0.995743
2009	0.998795
2010	0.997941

D. Claims Processing

The FI*/MAC* uses the following provider type codes to enable Pricer to calculate the appropriate rates for these facilities:

- 14 for a MDH that is not an RRC;
- 15 for a MDH that is also an RRC;
- 16 for a rebased SCH that is not an RRC; and
- 17 for a rebased SCH that is also an RRC.

The FI *or A/B MAC* calculates the *HSP rate and determines the greatest HSP rate (for SCHs, FY 1982, 1987, 1996 or 2006; for MDHs, FY 1982, 1987 or 2002). Then the FI or A/B MAC updates the HSP rate to the applicable FY and* enters *that* amount in the *PPS Facility Specific Rate* of the Provider-Specific File *(PSF)*, for *the applicable effective date. The HSP rate is to be entered* even if the Federal rate *is expected to result in higher payments than the applicable HSP rate.* Preloading *the applicable HSP rate* before the effective date is acceptable as long as the correct effective date is used for the

PSF record. The FI *or A/B MAC* leaves the field blank if the hospital *was* not *in operation during any of the applicable HSP base years*.

Pricer *will* calculate the payment based on the higher of the Federal rate or the *HSP* rate. *Where* the *HSP* rate is higher, Pricer reports the amount of the difference in the hospital-specific field. The FI *or A/B MAC* carries this amount forward in the hospital-specific payment field to its PS&R record for use at cost settlement.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for FI requirements for detecting duplicate claims in such cases.

B Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

0254 -	Drugs incident to other diagnostic services
0255 -	Drugs incident to radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341, 0343 -	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X -	CT scan
0371 -	Anesthesia incident to Radiology
0372 -	Anesthesia incident to other diagnostic services
040X -	Other imaging services
046X -	Pulmonary function
0471 -	Audiology diagnostic
0481, 0489-	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT

	codes 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 diagnostic
0482-	Cardiology, Stress Test
0483-	Cardiology, Echocardiology
053X -	Osteopathic services
061X -	MRT
062X -	Medical/surgical supplies, incident to radiology or other diagnostic services
073X -	EKG/ECG
074X -	EEG
0918-	Testing- Behavioral Health
092X -	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991)

Nondiagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the

patient's admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The FI shall assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B. This provision applies only when the patient has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008, CWF will reject *nondiagnostic* services when *the following is met:*

1) There is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay, and

2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

90.1.1 - The Standard Kidney Acquisition Charge

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and

- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge *on revenue code 081X. Such charges are not considered for the IPPS outlier calculation when a procedure code beginning with 556 is reported.*

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

A. Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B. Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C. Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the FI at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE:

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

D. Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E. Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F. Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number).

G. Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Applicable standard kidney acquisition charges are identified separately in FL 42 by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not**

included in the *kidney transplant* prospective payment. They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for procedure code 55.69 (kidney transplant). Where this procedure code is identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

90.2 - Heart Transplants

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A3-3613, HO-416

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

If a contractor has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of approved transplant centers, visit:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

A. Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987. All transplant hospitals will be recertified under the final rule, **Federal Register** / Vol. 72, No. 61 / Friday, March 30, 2007, / Rules and Regulations.

The CMS informs each hospital of its effective date in an approval letter.

B. Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C. Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. Charges for Heart Acquisition Services

The excising hospital bills the OPO, who in turn bills the transplant (implant) hospital for applicable services. It should not submit a bill to its contractor. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

Acquisition charges shall be billed on a 081X revenue code. Such charges are not considered for the IPPS outlier calculation when billed for a heart transplant.

E. Bill Review Procedures

The contractor takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1. Change in MCE Interface

The MCE creates a Limited Coverage edit for procedure code 37.51 (heart transplant). Where this procedure code is identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If payment is

appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

2. Handling Heart Transplant Billings From Nonapproved Hospitals

Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Form CMS-1450 or its electronic equivalent is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately in FL 42 by revenue code *081X*. Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are **not** included in *the liver transplant* prospective payment. They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code *081X* in the HUIP record that it sends to CWF and the QIO.

A. Bill Review Procedures

The contractor takes the following actions to process liver transplant bills.

1. Operative Report

The contractor requires the operative report with all claims for liver transplants, or sends a development request to the hospital for each liver transplant with a diagnosis code for a covered condition.

2. MCE Interface

Code 50.51 (Auxiliary liver transplant) is always a non-covered procedure. However, the MCE contains a limited coverage edit for procedure code 50.59 (liver transplant). Where procedure code 50.59 is identified by the MCE, the contractor shall check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant, and the contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If

yes, the claim is suspended for review of the operative report to determine whether the beneficiary has at least one of the covered conditions when the diagnosis code is for a covered condition. If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the contractor denies the claim.

NOTE: Some non-covered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. For example, primary biliary cirrhosis is a covered condition, secondary biliary cirrhosis is not a covered condition. Both primary and secondary biliary cirrhosis have the same **diagnosis** code ICD 9 571.6) Do not pay for noncovered conditions.

3. Grouper

If the bill shows a discharge date before March 8, 1990, the liver transplant procedure is not covered. If the discharge date is March 8, 1990 or later, the contractor processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigned CMS DRG 191 or 192. The contractor sent the bill to Pricer with review code 08. Pricer would then overlay CMS DRG 191 or 192 with CMS DRG 480 and the weights and thresholds for CMS DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns CMS DRG 480 and Pricer is able to price without using review code 08. If the discharge date is after September 30, 2007, Grouper assigns MS-DRG 005 or 006 (Liver transplant with MCC or Intestinal Transplant or Liver transplant without MCC, respectively) and Pricer is able to price without using review code 08.

4. Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The contractor will receive a copy of the letter.

90.5 - Pancreas Transplants Kidney Transplants

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. Background

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant (ICD-9-CM procedure code 55.69). Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

B. Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD-9-CM procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The contractor must determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

Diabetes Diagnosis Codes

250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

- Hypertensive Renal Diagnosis Codes:

403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure
585.1 - 585.6, 585.9	Chronic Renal Failure Code

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill 585.1 - 585.6, 585.9 on such a patient. In these cases one of the following V-codes should be present on the claim or in the beneficiary's history.

The provider uses the following V-codes only when a kidney transplant was performed before the pancreas transplant:

V42.0 Organ or tissue replaced by transplant kidney
V43.89 Organ tissue replaced by other means, kidney or pancreas

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a V-code.

C. Drugs

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D. Charges for Pancreas Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim. *In addition, the contractor remove acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.*

E. Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor rejects the claim, using the following MSN:

- MSN 16.32, "Medicare does not pay separately for this service."
- Use the following Remittance Advice Message:
- Claim adjustment reason code B15, "Claim/service denied/reduced because this procedure or service is not paid separately."

- If a claim is denied because no evidence of a prior kidney transplant is presented, use the following MSN message:

- MSN 15.4, "The information provided does not support the need for this service or item."

The contractor uses the following Remittance Advice Message:

- Claim adjustment reason code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

To further clarify the situation, the contractor should also use new claim level remark code MA 126, "Pancreas transplant not covered unless kidney transplant performed."

90.5.1 – Pancreas Transplants Alone (PA)

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

B. Nationally Covered Indications

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

C. Billing and Claims Processing

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

Contractors who receive claims for PA services that were performed in an unapproved facility, should reject such claims. Contractors should use the following messages upon the reject or denial:

> Medicare Summary Notice MSN Message - MSN code 16.2 (This service cannot be paid when provided in this location/facility)
>
> Remittance Advice Message - Claim Adjustment Reason Code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service)

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

All-Inclusive List of Covered ICD-9 CM Diagnosis Codes for PA

(**NOTE: "**X" = 1 and 3 only)

250.0X	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

Procedure Codes

ICD-9 CM

> 52.80 - Transplant of pancreas
>
> 52.82 - Homotransplant of pancreas

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers 52.80 and 52.82 as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient. Contractors should use the following messages upon the reject or denial:

Medicare Summary Notice MSN Message - MSN code 15.4 (The information provided does not support the need for this service or item)

Remittance Advice Message - Claim Adjustment Reason Code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer).

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

D. Charges for Pancreas Alone Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include PA in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for PA transplantation are billed in Revenue Code 081X. The contractor removes acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

A. Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at:
http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

C. Billing

ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. The Medicare Code Editor (MCE) lists this code as a limited coverage procedure. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For this procedure where the provider is approved as transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date, the contractor must suspend the claim for clerical review of the operative report to determine whether the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition.

This review is not part of the contractor's medical review workload. Instead, the contractor should complete this review as part of its claims processing workload.

Charges for ICD-9-CM procedure code 46.97 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD-9-CM procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

There is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include, but are not limited to:

• Volvulus 560.2,

• Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,

• Volvulus gastroschisis 569.89, other specified disorders of intestine,

o Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,

o Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,

o Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,

o Inflammatory bowel disease 569.9, unspecified disorder of intestine,

o Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and

o Radiation enteritis 558.1.

D. Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. *Therefore, acquisition charges billed on revenue code 081X are removed from the claim's total covered charges so as to not be included in the IPPS outlier calculation.* The Medicare Cost Report will include a separate line to account for these transplantation costs.

For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim and use MSN message 21.6, "This item or service is not covered when performed, referred, or ordered by this provider;" 21.18, "This item or service is not covered when performed or ordered by this provider;" or, 16.2, "This service cannot be paid when provided in this location/facility;" and Remittance Advice Message, Claim Adjustment Reason Code 52, "The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed."

100.8 – Replaced Devices Offered Without Cost or With a Credit

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Background

To identify and track claims billed for replacement devices, CMS issued CR 4058 on November 4, 2005. This CR provided instructions for billing and processing claims with the following condition codes:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.

- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

Policy

Beginning with discharges on or after October 1, 2008, CMS reduces Medicare payment when a replacement device is received by the hospital at a reduced cost or with a credit *that is 50 percent or greater than the cost of the device*, and when the assigned MS-DRG for the claim is one of the MS-DRGs applied to this policy.

For a list of MS-DRGs for which this policy applies to, please see the IPPS Final Rule.

This adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay.

Billing Procedures (Discharges on or after October 1, 2008)

To correctly bill for a replacement device that was provided with a credit or no cost, hospitals must use the combination of condition code 49 or 50, along with value code FD. The condition code 49 or 50 will identify a replacement device while value code FD will communicate to Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.

Payment (Discharges on or after October 1, 2008)

Medicare deducts the partial/full credit amount, reported in the amount for value code FD, from the final IPPS reimbursement when the assigned MS-DRG is one of the MS-DRGs applied to this policy.

140.3.1 - Shared Systems and CWF Edits

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

- To insure that revenue code 0024 is not reported more than once on bill type 11X;

- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.

- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);

- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);

- To reject subsequent claims with the same PPS provider on the same day (CWF);

- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date;

    - CWF accepts the incoming claim and sends an informational unsolicited response to the FI on the history claim if the patient status code does not match the incoming provider number

    - The FI cancels the history claim to the provider

- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim;

- CWF rejects the incoming claim if the patient status code does not match the provider number;

- FI returns the incoming claim to the provider for correction of the patient status code.

- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.

- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;

- Units entered on the 0024 must be accepted, but are not required.

- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,

- To insure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay $\leq$ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/

- The accommodation revenue code 018x (leave of absence) will continue to be used in the current manner including the appropriate occurrence span code 74 and date range.

150.9.1.3 - Payments for Special Cases

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Payments for short-stay outliers are determined in the Pricer logic. Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. For example, a case may be a short-stay outlier and also be governed by either the 3-day or less or greater than 3-day interruption of stay policy and therefore only generate 1 LTC-DRG payment to the LTCH.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

Hospitals within hospitals (HwH), satellite facilities, and onsite SNFs:

The LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, **all** such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)

- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

The LTCHs were required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the FIs within 60days of such a change. The implementation of the onsite policy is based on information maintained by

FIs on other Medicare providers co-located with LTCHs. FIs notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

Beginning FY 2005, an additional payment adjustment was established for LTCH HwHs and satellites of HwHs relating to the percentage of patients discharged during a specific cost reporting period that were admitted from their host hospital. Effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs and satellites of HwHs discharging patients from their host hospital was extended to govern discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes discharges from "grandfathered" LTCH HwHs and LTCH satellites that were admitted from their host hospitals; LTCH and LTCH satellite discharges from referring hospitals that are not co-located with the discharging facility; and discharges from "free-standing" LTCHs that were admitted from any referring hospital.

Basic Payment Formula under the 25 Percent Threshold Payment Adjustment for Medicare Discharges from Referring Hospitals

NOTE: On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted with mandated several modifications to this policy for a 3-year period beginning on the date of enactment of the Act. For clarity, each modification to the policy is specified in a bullet point immediately below the explanation of the particular aspect of the policy as it was effective on July 1, 2007. *The bullet points below also include additional amendments made by the enactment of the American Recovery and Reinvestment Act (ARRA) of 2009 on February 17, 2009, to the 25 percent threshold payment adjustment. It is important to note that for those policies that operate on an October 1 cycle (i.e. pre-MMSEA regulations at 42 CFR §412.534), the ARRA has amended the MMSEA so that the MMSEA relief is effective for cost reporting periods beginning on or after October 1, 2009, and before October 1, 2010. For policies that operate on a July 1 cycle, (e.g., pre-MMSEA regulations at 42 CFR 412.534(h) and §412. 536) the ARRA amendments to the MMSEA relief are effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.*

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**
    - This policy was finalized for FY 2005

- If a LTCH HwH or satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. For LTCHs and LTCH satellites subject to the transition period described below, there is a 3-year transition to the full 25 percent threshold payment adjustment.

As amended by the MMSEA of 2007:

- The percentage threshold for "applicable" LTCHs and LTCH satellites (i.e., subject to the transition described below) is raised from 25 percent to 50 percent for LTCH cost reporting periods beginning on or after *October1, 2007, and before October 1, 2010. "Grandfathered" LTCH satellites are also "applicable" for this increase, under the ARRA but on a July 1 cycle, as noted above.*

- For LTCHs with "special circumstances," specified below, the 50 percent threshold is raised to 75 percent for the same 3-year period.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to Grandfathered LTCH HwHs and LTCH Satellites from their Host Hospitals**

  Prior to the enactment of the MMSEA and the ARRA, this policy *was* effective for cost reporting periods beginning on or after July 1, 2007.

  - Subject to the 3-year transition described below, if a grandfathered LTCH HwH or a grandfathered satellite of a LTCH has admitted from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the LTCH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS.

  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

- **Admitted to all LTCHs and LTCH Satellites from Referring Hospitals other than those with which they are Co-located:**

- This policy is effective for cost reporting periods beginning on or after July 1, 2007.

- Subject to the 3-year transition specified below, if a LTCH or LTCH satellite admits from its host hospital in excess of 25 percent or the applicable percentage) of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS. *(See details of this payment adjustment below the discussion of the MMSEA and the ARRA changes.)*

- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As amended by the MMSEA of 2007:

- *For cost reporting periods beginning on or after July 1, 2007, and before July 1,, 2010, grandfathered LTCH HwHs are exempted from the 25 percent threshold for admissions from co-located hospitals or referring hospitals with which they are not co-located.*

- *"Freestanding" LTCHs, i.e., LTCHs not co-located with another hospital as a HwH or as a satellite are exempted from the 25 percent threshold for admissions from any referring hospital.*

As amended by the ARRA of 2009:

- *The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located.*

The 3-year delay in the application of the percentage threshold payment adjustment for each of the above categories is effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010.

NOTE: For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010 or on or after October 1, 2007, and before October 1, 2010, as applicable (see explanation above), this payment adjustment continues to be applicable under the specific circumstances set forth in the MMSEA and the ARRA.

Payment adjustment under the 25 percent threshold payment policy

Under the LTCH PPS, payments for LTCH or LTCH discharges in excess of the specified threshold percentages are based on the lesser of an amount otherwise payable under the LTCH PPS or an amount that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located and the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule. For LTCHs located in Alaska and Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, an amount equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment and where applicable, an IME adjustment.

Additionally, to arrive at the payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted by the applicable geographic adjustment factors set forth, including local cost variation (based on the IPPS wage index for non-reclassified hospitals published in the annual IPPS final rule), large urban location, and COLA, if applicable.

For discharges governed by this payment, an amount that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment if applicable, and an equivalent IME adjustment), if applicable.

An amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since, under the IPPS, there are separate Medicare rates for operating and capital costs to acute care hospitals, while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospital's services provided to LTCH Medicare patients.

Note that there is a difference between the policy that we have codified for adjusted payments to LTCH HwHs and satellites of LTCHs, which is based on an amount "equivalent" under the existing payment, and the additional component to the SSO payment adjustment that is based on an amount "comparable" to what would otherwise be paid under the IPPS adjustment. The distinction is that if a SSO case also qualifies as a

high cost outlier (HCO) case after the SSO payment amount is determined, the SSO payment formula uses the LTCH PPS fixed loss amount. In contrast, under the payment adjustment for LTCH HwHs and LTCH satellites if the amount payable by Medicare for a specific case is equivalent to what would be otherwise payable under the IPPS and the case also qualified as a HCO, the outlier payment for this case would be based on the IPPS HCO policy because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment the lesser amount resulted in an "otherwise payable amount under the LTCH PPS," and the stay qualified as a HCO, Medicare would generate a HCO payment governed by the LTCH PPS fixed loss amount calculated under the LTCH PPS and if the estimated cost of the case exceeds the adjusted LTC-DRG plus a fixed loss amount under §412.525(a), the LTCH would receive an additional payment based on the LTCH PPS HCO policy.

Specific Circumstances (applicable to all of the above scenarios)

NOTE: MMSEA changes described above applicable for cost reporting periods beginning on or after *October 1*, 2007, and before *October 1*, 2010, *or July 1 2007 and before July 1, 2010, as applicable.(as amended by the ARRA).*

- For LTCHs and LTCH satellites located in rural areas, instead of the 25 percent threshold, we provide for a 50 percent threshold for patients from any individual referral hospital. In addition, in determining the percentage of patients admitted from that referring hospital, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital. *Under MMSEA, the 25 percentage threshold is increased to 50 percent for applicable LTCH HwHs, satellites, and grandfathered satellites.*

- For urban single or MSA dominant referring hospitals, we would allow the LTCH or LTCH satellite to admit from the host up to the referring hospital's percentage of total Medicare discharges in the MSA. A floor of 25 percent and a ceiling of 51 percent applied to this variation. *Under MMSEA, the 50 percentage threshold is increased to 75 percent.*

Transition Periods

For Medicare discharges from referring hospitals:

- **Admitted to co-located LTCHs and LTCH satellites from their host hospitals**
  - This policy was finalized for FY 2005.

This payment adjustment will be phased-in over 4 years for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

- On or before October 1, 2004 they have certification as acute care hospitals, under Part 489; and

- Before October 1, 2005 designation as a LTCH.

For purposes of full payment under the LTCH PPS during the transition period, the percentage of discharges from the LTCH HwH originating from the host hospital for each applicable cost reporting period, may not exceed the percentage of discharges during the hospital's cost reporting period during FY 2004 that were admitted from the host hospital.

Year 1 -- (cost reporting periods beginning on or after October 1, 2004 through September 30, 2005) a "hold harmless"

- Payments will be made under the LTCH PPS but the percentage of LTCH HwH discharges originating from the host may not exceed the percentage for such patients established for cost reporting periods during FY 2004.

Year 2 -- (cost reporting periods beginning on or after October 1, 2005 through September 30, 2006)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 -- (cost reporting periods beginning on or after October 1, 2006 through September 30, 2007)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the lesser of the percentage of those patients for their FY 2004 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 4 -- (cost reporting periods beginning on or after October 1, 2007 through September 30, 2008)

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not

exceed the 25 percent or the applicable percentage described for "specific circumstances above."

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Transition Period for all LTCHs affected by the Above Described Regulations for cost reporting periods beginning on or after July 1, 2008.

NOTE: MMSEA changes described above applicable for cost reporting periods beginning on or after *July 1*, 2007, and before *July 1*, 2010, for "grandfathered" LTCH HwHs and "freestanding" LTCHs.

The full payment threshold adjustment will be phased in over 3-years as follows:

Year 1 - (for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008)

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 75 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 2 - (for cost reporting periods on or after July 1, 2008 through June 30, 2009),

- LTCHs and LTCH satellites will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from a referring hospital that do not exceed the lesser of the percentage of those patients for their RY 2005 cost reporting period or 50 percent.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Year 3 - (for cost reporting periods on or after July 1, 2009)

- All LTCHs and LTCH satellites subject to the payment threshold policy effective for RY 2008, will be subject to the 25 percent (or applicable percentage) threshold.

- For discharges in excess of that threshold, the payments will be determined under "the basic payment formula" specified above.

Implementation:

- The payment threshold policy for discharges from co-located LTCH HwHs and LTCH satellites admitted from their hosts (including grandfathered LTCH HwHs and satellites) is determined based on a location-specific basis.

- The payment threshold policy for discharges from LTCHs and LTCH satellites admitted from referring hospitals with which they are not co-located is determined based upon provider numbers for both the LTCH and the referring hospital.

For LTCHs and LTCH satellites subject to both the FY 2005 and the RY 2008 threshold payment adjustment policies

- If a co-located LTCH or a co-located referring hospital (host) shares a provider number with a hospital or satellite at another location, threshold determinations will continue to be location-specific for the co-located LTCH and host. The threshold percentage determinations will be applied to all other location or campus of either a LTCH or referring hospital in the aggregate. For example, when the policy finalized for RY 2008 is fully phased in, a co-located LTCH (LTCH A) and host (referring hospital A) will have a 25 percent threshold under the policy finalized for FY 2005. If referring hospital A shares a provider number with a remote location (RH A'), then another 25 percent threshold will be applied to patients discharged from LTCH A that were admitted RH A'.

- We note that for cost reporting periods beginning on or after October 1, 2007, non-grandfathered co-located LTCHs, are fully phased-in to the full 25 percent (or applicable percentage threshold) for discharges admitted from their co-located hosts (under the initial 25 percent payment threshold established for FY 2005)s.

- However, for discharges admitted from non-co-located referring hospitals, these LTCH HwHs and satellites are governed by the policy finalized for RY 2008. Therefore, for cost reporting periods beginning on or after July 1, 2007 through June 30, 2008, the 75 percent threshold will apply, and the 50 percent threshold will apply for cost reporting periods beginning on or after July 1, 2008 through June 30, 2009 as described above in this response.)

- Furthermore, under our finalized policy for RY 2008, grandfathered LTCH HwHs and satellites will be subject to the 3-year transition that we are finalizing under this new policy for <u>all</u> their discharges, both admitted from their co-located host and from other non-co-located referring hospitals.

When both policies apply:

If a patient discharged from a LTCH HwH or satellite was originally admitted from the host hospital and immediately prior to that admission to the host, the patient was being treated at the same LTCH HwH or LTCH satellite, both of the policies described in this section, the 5 percent on-site policy as well as the 25 percent policy are applicable. In such a case, the following procedures should be followed keeping in mind that the 5 percent rule affects number of discharges and the 25 percent rule affects payment.

- The on-site 5 percent computation is first in order to determine the real number of discharges.

- Focusing on the relationship between an acute host and a LTCH HwH/satellite, if the number of revolving door discharges between these two facilities exceeds 5 percent during a CR period, this policy will collapse the number of discharges within that CR period, halving the # of revolving door LTCH stays where the intervening stay exceeded the threshold and eliminating from consideration those host stays that were bracketed by two LTCH stays. All such stays for the entire cost reporting period will be paid as one LTCH PPS stay.

- The next issue is to determine which of these stays will be paid an unadjusted LTCH PPS rate and which will be paid an amount equivalent to what would otherwise be paid under the IPPS. Cases prior to tripping the 25 percent threshold will be paid the otherwise unadjusted LTCH PPS rate and those after the threshold that had not achieved outlier status at the host it will be paid based on the adjustment.

- Because of the 5 percent policy that collapsed the discharges from the LTCH, for purposes of the 25 percent policy, we are focusing on fewer discharges in total from the LTCH and we need to determine what percent of these discharges originated in the host so that we can apply the payment adjustment.

BUT, in the event that the 5 percent is not tripped during that cost reporting period, each acute-->LTCH-->acute--> LTCH cycle, which will count as two LTCH discharges originating in the host for purposes of the 25 percent policy, since both the first and second LTCH admission were from the host.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

230 – Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient
(Rev. 1816; Issued: 09-17-09; Effective Date: Discharges on or after October 1, 2009; Implementation Date: 10-05-09)

The Centers for Medicare & Medicaid Services (CMS) internally generated a request for a national coverage analysis (NCA) to establish national coverage determinations (NCDs) addressing Medicare coverage of Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient. Information regarding these NCDs can be found in Publication (Pub.) 100-03, chapter 1, sections 140.6, 140.7, and 140.8, respectively.

Inpatient Claims

Hospitals are required to bill two claims when a surgical error is reported and a covered service is also being reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and
- The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim)

NOTE: Both the covered and non-covered claim shall have a matching Statement Covers Period.

For discharges prior to October 1, 2009, the non-covered TOB 110 must indicate in Form Locator (FL) 80 (Remarks), or on the 837i at Loop 2300, Billing Note NTE01=ADD, NTE02, one of the applicable erroneous surgery(s) two-digit codes (entered exactly as specified below):

- For a wrong surgery on patient, enter the following: **MX**
- For a surgery on a wrong body part, enter the following: **MY**
- For a surgery on wrong patient, enter the following: **MZ**

For discharges on or after October 1, 2009, the non-covered TOB 110 must have one of the following ICD-9- CM diagnosis code reported in diagnosis position 2-9, instead of billing the aforementioned two-digit codes in Remarks:

- ***E876.5*** *- Performance of wrong operation (procedure) on correct patient (existing code)*
- ***E876.6*** *- Performance of operation (procedure) on patient not scheduled for surgery*
- ***E876.7****- Performance of correct operation (procedure) on wrong side/body part*

Note: The above codes shall not be reported in the External Cause of Injury (E-code) field.

Outpatient, Ambulatory Surgical Centers, and Practitioner Claims

Providers are required to append one of the following applicable HCPCS modifiers to all lines related to the erroneous surgery(s):

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

All claims

*Claim/*Lines submitted with a surgical error will be *denied/*line-item denied using the following:

Medicare Summary Notice
23.17 – Medicare won't cover these services because they are not considered medically necessary."
23.17 – Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas.

Claim Adjustment Reason Code
CARC 50 – These are non-covered services because this is not deemed a 'medical necessity" by the payer.

Group Code
CO – Contractual Obligation

Beneficiary Liability

Generally, beneficiary liability notices such an Advance Beneficiary Notice of Non-coverage (ABN) or a Hospital Issued Notice of Non-coverage (HINN) is appropriate when a provider is furnishing an item or service that the provider reasonably believes Medicare will not cover on the basis of §1862(a)(1). An ABN must include all of the elements described in Pub. 100-04, Claims Processing Manual (CPM), Ch. 30, §50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item or service expected to be denied (e.g. a left leg amputation) and must include a cost estimate for the non-covered item or service. Similarly, HINNs must specifically

describe the item or service expected to be denied (e.g. a left leg amputation) and must include all of the elements described in the instructions found in the CPM Ch. 3,0 §200. Thus, a provider cannot shift financial liability for the non-covered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in the CPM Ch. 30, §50.6.3 and §200, respectively. Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing services related to the follow-up care for the non-covered surgical error that would not be considered a related service to the non-covered surgical error.