

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-20 One-Time Notification</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 842</b>	<b>Date: January 21, 2011</b>
	<b>Change Request 7244</b>

**SUBJECT: Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Pricer to Accept Diagnosis Codes and to Pass a Low-Volume Payment Amount**

**I. SUMMARY OF CHANGES:** This CR is providing instruction to the Fiscal Intermediary Shared System to send new data elements to the IPPS Pricer.

**EFFECTIVE DATE: July 1, 2011**

**IMPLEMENTATION DATE: July 5, 2011**

*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/revise 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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

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

**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:**

**One-Time Notification**

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

# Attachment – One-Time Notification

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**SUBJECT: Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Pricer to Accept Diagnosis Codes and to Pass a Low-Volume Payment Amount**

**Effective Date:** July 1, 2011

**Implementation Date:** July 5, 2011

## I. GENERAL INFORMATION

**A. Background:** For certain hospitals that qualify for the low-volume payment adjustment under the Inpatient Prospective Payment Systems (IPPS). The low-volume payment amount calculated by the IPPS Pricer may be an estimated interim payment. The low-volume payment amount is subject to a year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example payments for Disproportionate Share Hospital (DSH) or Indirect Medical Education (IME) or Federal rate versus Hospital Specific rate payments for Sole Community Hospitals (SCHs) / Medicare Dependent Hospitals (MDHs)). Currently, the low-volume payment amount calculated by the IPPS Pricer is not sent to the Fiscal Intermediary Shared System (FISS). Therefore, contractors do not have the capability to recalculate the low-volume payment amount at cost report settlement. This Change Request (CR) is instructing FISS to accept the new low-volume payment amount field from the IPPS Pricer to provide contractors access to the low-volume payment amount calculated by the IPPS Pricer. Further guidance on recalculation of the low-volume payment adjustment at cost report settlement is forthcoming in a separate communication.

In addition to the low-volume payment amount described above, to accommodate future new technology payment logic, the IPPS Pricer is being modified to accept the 25 diagnosis code fields (1 principal plus 24 secondary diagnosis codes) on the bill record. Since FISS does not currently send any diagnosis codes on the IPPS bill record, FISS will need to expand the IPPS bill record file to pass the 25 diagnosis codes to the IPPS Pricer. Therefore, this CR also instructs FISS to expand the IPPS bill record to include up to 25 diagnosis code fields and to pass these fields to the IPPS Pricer. This expansion of including the diagnosis codes in FISS is consistent with Change Request 7004 (which is effective January 2, 2011) which expands the number of procedure codes in FISS from 6 to 25.

Lastly, CMS is revising the FY 2003 & FY 2004 IPPS Pricer to assign a different Labor Share Percentage for certain providers for future adjustments, which will be provided in future instructions to the contractors.

**B. Policy:** Section 1886(d)(12) of the Social Security Act provides for a payment adjustment to account for the higher costs per discharge for “low-volume hospitals” under the IPPS, effective beginning with discharges occurring in fiscal year (FY) 2005. Sections 3125 and 10314 of the Affordable Care Act amended section 1886(d)(12) of the Act by revising the definition of a “low-volume hospital” and by revising the methodology for calculating the payment adjustment for low-volume hospitals for FYs 2011 and 2012, as discussed in CR 7134 (Transmittal 2060; October 1, 2010). For FY 2013 and subsequent years, the low-volume hospital payment adjustment and qualifying criteria that existed prior to the Affordable Care Act will resume.

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, "based on the estimated costs incurred with

respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate." Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered "new" if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 412.87 establishes the criteria for new technologies to qualify for new technology add-on payments. We use diagnosis and procedure codes in order to uniquely identify new technologies eligible for new technology add-on payments.

## II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M  M A C	F I  M A C	C A R I E R	R H R I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7244.1	The Inpatient Prospective Payment System (IPPS) Pricer shall populate the Prospective Payment System low volume payment amount field to send to FISS.  PPS-LOW-VOL-PAYMENT - PIC 9(07)V9(02)										IPPS Pricer
7244.2	Contractors shall accept the new low volume payment amount field mentioned above.						X			X	NCH PS&R IDR
7244.2.1	Contractors shall ensure the low volume payment amount field is captured in PS&R.						X				PS&R
7244.2.2	FISS shall receive the low volume payment amount from the IPPS Pricer and populate this amount into payer-only value code 74.						X				
7244.2.3	FISS shall update the DRG Cost Disclosure Inquiry Screens in DDE for both Contractor and Provider viewing.						X				
7244.3	FISS shall send all diagnosis codes (up to 25) to the IPPS Pricer on the bill record.						X				
7244.4	The IPPS Pricer shall accept diagnosis codes from FISS.										IPPS Pricer
7244.5	FISS shall install the revised IPPS Pricer for FY 2003 into the FISS Pricer utility (per CR 7192).						X				
7244.6	FISS shall install the revised IPPS Pricer for FY 2004 into the FISS Pricer utility (per CR 7192).						X				

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E A C	F I	C A R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
7244.7	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>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.</p>	X		X						

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space: N/A**

### V. CONTACTS

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**Post-Implementation Contact(s):** Regional Office

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *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)*, 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.