CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1374	**Date: NOVEMBER 7, 2007**
	Change Request 5748

NOTE: Transmittal 1354, sent on October 18, 2007, is rescinded and replaced with this transmittal because the Recurring Update Notification was incorrect. We have corrected the Recurring Update Notification to include information regarding the availability of the final IPPS rates, and also information regarding the -0.6 percent documentation & coding adjustment. All other information remains the same.

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

I. SUMMARY OF CHANGES: This Change Request (CR) announces changes to the IPPS and LTCH PPS payment policies based on the FY 08 IPPS Final Rule. It also includes the ICD-9-CM coding changes that affect the IPF PPS comorbidity adjustment.

New / Revised Material
Effective Date: **Discharges on and after October 1, 2007**
Implementation Date: October 18, 2007

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
N/A	

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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1374	Date: November 7, 2007	Change Request: 5748

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Effective Date: **Discharges on and after October 1, 2007**
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I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes for IPPS hospitals for FY 2008. The policy changes for FY 2008 appeared in the **Federal Register** on August 22, 2007. The final IPPS rates are available on the CMS Web site. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2007, unless otherwise noted.

Additionally, this CR also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2007, for hospitals paid under the IPPS, as well as under LTCH PPS. The LTCH PPS rate changes occurred on July 1, 2007. (Please refer to Transmittal 1268, CR 5652, published on June 15, 2007, for LTCH policy changes.) The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2007. IPF PPS rate changes occurred on July 1, 2007. Please refer to Transmittal 1256, CR 5619, published on May 25, 2007 for IPF PPS policy changes.

Finally, the FY 2008 hospital inpatient prospective payment system (IPPS) final rule (published in the Federal Register on August 22, 2007 (72 FR 47130 through 48175)) established a new DRG system, the Medicare Severity DRGs (MS-DRGs), effective October 1, 2007. By better taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. To ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without corresponding growth in actual patient severity, the FY 2008 IPPS final rule established a documentation and coding adjustment of -1.2 percent for FY 2008.

On September 29, 2007, the President signed into law the "TMA, Abstinence Education, and QI Programs Extension Act of 2007," which includes a provision concerning the documentation and coding adjustment for the MS-DRGs. Specifically with respect to FY 2008, section 7 of this law specifies that in implementing the FY 2008 IPPS final rule, for discharges occurring during FY 2008, the documentation and coding adjustment made in response to the implementation of a MS-DRG system shall be -0.6 percent rather than the -1.2 percent specified in the final rule.

B. Policy: Consistent with the "TMA, Abstinence Education, and QI Programs Extension Act of 2007," we have revised the FY 2008 IPPS operating and capital rates to reflect a -0.6 percent adjustment for documentation and coding, instead of a -1.2 percent. This change to the IPPS payment rates also results in a revision to the outlier threshold for FY 2008 in order to maintain our estimate that operating outlier payments are projected to be equal to 5.1 percent of total operating MS-DRG payments.

We also note that the -0.6 percent documentation & coding adjustment is not being applied to the hospital-specific rates in the Pricer, consistent with the policy established in the IPPS notice issued on November 1, 2007, (which can be downloaded from the CMS Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/IPPS/list.asp#TopOfPage).

ICD-9-CM Changes

The ICD-9-CM coding changes are effective October 1, 2007. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables and 6b of the August 22, 2007, **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 DRG Grouper Contractor, 3M-HIS, introduced a new DRG Grouper, Version 25, software package effective for discharges on or after October 1, 2007.

The GROUPER 25.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status), and is effective with discharges occurring on or after October 1, 2007. The Medicare Code Editor (MCE) 24.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2007.

1. Furnished Software Changes

The following software programs were issued for FY 2008:

a. IPPS PRICER FY 08 for discharges occurring on or after October 1, 2007. The IPPS Pricer 08 processes bills with discharge dates on or after October 1, 2002.

(1.) Rates:

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

MDH/SCH Budget Neutrality Factor	0.995743

(2.) Operating:

RATES W/ FULL MB & WI GT 1

	LS	NLS
National	3478.45	1512.15
PR National	3478.45	1512.15
PR Specific	1462.27	896.23

RATES W/ FULL MB & WI LT 1

	LS	NLS
National	3094.17	1896.43
PR National	3094.17	1896.43
PR Specific	1384.44	974.06

RATES W/ REDUCED MB & WI GT 1

	LS	NLS
National	3411.10	1482.87

RATES W/ REDUCED MB & WI LT 1

	LS	NLS
National	3034.26	1859.71

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

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

(3.) Postacute Care Transfer Policy

The DRGs determined in the post acute care transfer policy have been modified due to MS-DRGs. The special pay DRGs are (these are paid at 50% of the appropriate PPS rate for the first day of the stay and 50% of the amount calculated for the rest of the stay):

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

See attachment A for list of the post acute care transfer DRGs

(4.) New Technology Add-On Payment
Effective for discharges on or after October 1, 2007, there will be no continuing add-on payments from last year and no new ones starting for this year.

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

2. GROUPER 25.0 for discharges occurring on or after October 1, 2007. PRICER calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation on or about August 1, 2007. This version of Grouper will include logic to group to Medicare Severity DRGs or MS-DRGS. Grouper will have increased field lengths for the diagnosis and procedure codes and dates and fields for the POA indicator. MS-DRGs are a modification of the CMS-DRGs to better account for severity of illness and resource consumption for Medicare patients. The MS-DRGs increase the number of DRGs by 207 to a total of 745, while maintaining the reasonable patient volume in each DRG. There are three levels of severity in the MS-DRGs based on the secondary diagnosis codes: MCC (Major Complication/Comorbidity), CC (Complication/Comorbidity), and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the CMS DRGs or the MS-DRGs.

3. Medicare Coding Editor (MCE) 24.0 for discharges occurring on or after October 1, 2007. The MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation on or about August 1, 2007. Effective October 1, 2007, MCE will have increased field lengths for diagnosis and procedure codes, fields for the present on admission (POA) indicator, other new edits and retroactivity.

4. 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 provider IPPS (PROV) file for each hospital as needed, and update the following fields for IPPS hospitals effective October 1, 2007, or effective with the cost reporting period that begins on or after October 1, 2007, or upon receipt of an as-filed (tentatively) settled cost report.

- Residents/beds ratio;
- Hospital beds;

- Operating cost-to-charge ratio;
- Fiscal year beginning date;
- Pass through amounts (for non-PPS and new hospitals);
- SSI ratio;
- Medicaid ratio;
- Update the Special Payment Indicator (if applicable);
- If a hospital has been reclassified for FY 2008, update the wage index CBSA;
- Old capital hold-harmless rate;
- New capital hold-harmless rate;
- Capital cost-to-charge ratio;
- New hospital indicator: Overlay the "Y" with a blank if the period is more than two years after the provider accepted its first patient;
- Capital indirect medical education ratio;
- Capital exception payment rate (as applicable)
- Effective date (this field is required at a minimum every October to maintain the functionality of the PSFs maintained by CMS.)
- Temporary Relief Indicator for “low volume” hospital (see 2 below);
- Enter “1” in the Hospital Quality Indicator field if applicable; and
- Case Mix Index Adjusted Cost per Discharge.

Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2008 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.238 and the capital ceiling is 0.152.

a. CBSA Designations

Attachment B shows the IPPS providers that will be receiving a "special" wage index for FY 2008 (i.e., receives an out-commuting adjustment under section 505 of the MMA). For any provider with a Special Wage Index from FY 2007, FIs shall remove that special wage index, unless they receive a new special wage index as listed in Attachment B.

Sunset of the Hold Harmless Provision

Micropolitan areas are “rural” areas, but hospitals located in these areas were given an urban area wage index for 3 years (know as the “hold-harmless” provision). This provision expires 9/30/07. Hospitals shall receive 100 percent of their wage index based upon the CBSA configurations. CBSAs that are MSAs are considered urban, and CBSAs that are Micropolitan Statistical Areas, as well as, areas outside of CBSAs are considered rural.

Contractors shall update their PSF by removing the 5-digit hold harmless CBSA designation from hospitals located in micropolitan areas and use the rural CBSA designation.

b. Low Volume Hospitals

FIs 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% bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify FIs if they believe they are a low volume hospital.

The Low Volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination. If the hospital is no longer low volume, the 'Y' indicator should be removed. If the hospital does meet the low volume criteria, a 'Y' should be inserted into the low volume indicator field.

c. Hospital Quality Initiative

The FIs 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 website: www.qualitynet.org. This website is expected to be updated during September FY 2008. **Attachment C** includes the list of providers that did not meet the criteria for FY 08. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website and FIs must update the provider file as needed. (CMS is expected to have the list of Quality Hospitals on or about 9/7/07, therefore the list will be included in the Final of this CR.)

For new hospitals, FIs 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 must provide this information monthly to the QIO in the State in which the hospital has opened. It should include the following:

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

5. Other Changes

Capital PPS Adjustment for Hospitals Located in Large Urban Areas

In the FY 2008 final rule, the capital PPS 3.0 percent "large urban add-on" was eliminated effective for discharges on or after October 1, 2007. That is, the regulations at §412.316(b) were revised to specify that beginning in FY 2008 and after, there will no longer be any additional payment under the capital

PPS for hospitals located in large urban areas, as currently provided under that section. The PRICER has been updated to reflect this policy change.

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

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 "Lugar 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 must 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 must 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 must 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.

LTCH Changes

A new patient classification system is being adopted under the LTCH PPS , beginning in FY 2008, it is the same as the one being adopted under the IPPS (i.e., MS-DRGs), under LTCH the DRGs are referred to as "MS-LTC-DRGs."

Pricer

The LTCH Pricer has been updated with the MS-LTC-DRG table and weights.

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

Inpatient Psychiatric Facility Changes

Coding Changes

DRG Adjustment Update:

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of our identified 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

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

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

(v24) DRG	(v25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521- 522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88

523	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	

Comorbidity Adjustment Update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of 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 are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. 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.

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

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

The table below lists the FY 2008 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2008 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

Diagnosis Code	Description	Comorbidity Category
040.41	Infant botulism	Infectious Diseases
040.42	Wound botulism	Infectious Diseases
058.10	Roseola infantum, unspecified	Infectious Diseases
058.11	Roseola infantum due to human herpesvirus 6	Infectious Diseases
058.12	Roseola infantum due to human herpesvirus 7	Infectious Diseases
058.21	Human herpesvirus 6 encephalitis	Infectious Diseases
058.29	Other human herpesvirus encephalitis	Infectious Diseases
058.81	Human herpesvirus 6 infection	Infectious Diseases
058.82	Human herpesvirus 7 infection	Infectious Diseases
058.89	Other human herpesvirus infection	Infectious Diseases
200.30	Marginal zone lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
200.31	Marginal zone lymphoma, lymph nodes of head, face, and neck	Oncology Treatment

Diagnosis Code	Description	Comorbidity Category
200.32	Marginal zone lymphoma, intrathoracic lymph nodes	Oncology Treatment
200.33	Marginal zone lymphoma, intraabdominal lymph nodes	Oncology Treatment
200.34	Marginal zone lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
200.35	Marginal zone lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
200.36	Marginal zone lymphoma, intrapelvic lymph nodes	Oncology Treatment
200.37	Marginal zone lymphoma, spleen	Oncology Treatment
200.38	Marginal zone lymphoma, lymph nodes of multiple sites	Oncology Treatment
200.40	Mantle cell lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
200.41	Mantle cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment
200.42	Mantle cell lymphoma, intrathoracic lymph nodes	Oncology Treatment
200.43	Mantle cell lymphoma, intra abdominal lymph nodes	Oncology Treatment
200.44	Mantle cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
200.45	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
200.46	Mantle cell lymphoma, intrapelvic lymph nodes	Oncology Treatment
200.47	Mantle cell lymphoma, spleen	Oncology Treatment
200.48	Mantle cell lymphoma, lymph nodes of multiple sites	Oncology Treatment
200.50	Primary central nervous system lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
200.51	Primary central nervous system lymphoma, lymph nodes of head, face, and neck	Oncology Treatment
200.52	Primary central nervous system lymphoma, intrathoracic lymph nodes	Oncology Treatment
200.53	Primary central nervous system lymphoma, intra-abdominal lymph nodes	Oncology Treatment
200.54	Primary central nervous system lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
200.55	Primary central nervous system lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
200.56	Primary central nervous system lymphoma, intrapelvic lymph nodes	Oncology Treatment
200.57	Primary central nervous system lymphoma, spleen	Oncology Treatment
200.58	Primary central nervous system lymphoma, lymph nodes of multiple sites	Oncology Treatment
200.60	Anaplastic large cell lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
200.61	Anaplastic large cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment
200.62	Anaplastic large cell lymphoma, intrathoracic lymph nodes	Oncology Treatment

Diagnosis Code	Description	Comorbidity Category
200.63	Anaplastic large cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment
200.64	Anaplastic large cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
200.65	Anaplastic large cell lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
200.66	Anaplastic large cell lymphoma, intrapelvic lymph nodes	Oncology Treatment
200.67	Anaplastic large cell lymphoma, spleen	Oncology Treatment
200.68	Anaplastic large cell lymphoma, lymph nodes of multiple sites	Oncology Treatment
200.70	Large cell lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
200.71	Large cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment
200.72	Large cell lymphoma, intrathoracic lymph nodes	Oncology Treatment
200.73	Large cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment
200.74	Large cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
200.75	Large cell lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
200.76	Large cell lymphoma, intrapelvic lymph nodes	Oncology Treatment
200.77	Large cell lymphoma, spleen	Oncology Treatment
200.78	Large cell lymphoma, lymph nodes of multiple sites	Oncology Treatment
202.70	Peripheral T cell lymphoma, unspecified site, extranodal and solid organ sites	Oncology Treatment
202.71	Peripheral T cell lymphoma, lymph nodes of head, face, and neck	Oncology Treatment
202.72	Peripheral T cell lymphoma, intrathoracic lymph nodes	Oncology Treatment
202.73	Peripheral T cell lymphoma, intra-abdominal lymph nodes	Oncology Treatment
202.74	Peripheral T cell lymphoma, lymph nodes of axilla and upper limb	Oncology Treatment
202.75	Peripheral T cell lymphoma, lymph nodes of inguinal region and lower limb	Oncology Treatment
202.76	Peripheral T cell lymphoma, intrapelvic lymph nodes	Oncology Treatment
202.77	Peripheral T cell lymphoma, spleen	Oncology Treatment
202.78	Peripheral T cell lymphoma, lymph nodes of multiple sites	Oncology Treatment
233.30	Carcinoma in situ, unspecified female genital organ	Oncology Treatment
233.31	Carcinoma in situ,vagina	Oncology Treatment
233.32	Carcinoma in situ,vulva	Oncology Treatment
233.39	Carcinoma in situ, other female genital organ	Oncology Treatment

The table below lists the invalid ICD-9-CM codes no longer applicable for the comorbidity adjustment. This table does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

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

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5748.1	FISS shall install and pay claims with the FY 2008 IPPS Pricer for discharges on and after October 1, 2007.						X				
5748.2	FISS shall install and pay claims with the LTCH Pricer for discharges on and after October 1, 2007.						X				
5748.3	FISS shall install and pay claims with the IPF Pricer for discharges on and after October 1, 2007.						X				
5748.4	FISS shall install and edit claims with the MCE version 24.0 and GROUPER version 25.0 software with the implementation of the October quarterly release.						X				
5748.5	CWF shall update edit 7272 with the postacute care DRGs listed in this CR effective for discharges on or after October 1, 2007 (includes special pay).									X	
5748.6	Contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X		X							
5748.7	Contractors shall update relevant portions of the provider specific file in accordance with section 4.	X		X							
5748.8	The CWF shall update edit E46#P/U5401 to exclude OPPS claims with modifier –CA.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement									
		A/	DM	FI	CA	RH	Shared-System Maintainers			OTHER

		B M A C	E M A C		R R I E R	H I	F I S S	M C S	V M S	C W F	
5748.9	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 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 1 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.	X		X							

IV. SUPPORTING INFORMATION

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:

B. For all other recommendations and supporting information, use this space: N\A

V. CONTACTS

Pre-Implementation Contact(s): Valeri Ritter at Valeri.ritter@cms.hhs.gov or Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers,* use the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Special Wage Indexes for FY 2008

PROV #	FY 2008 WI
010008	0.7741
010015	0.7613
010032	0.7892
010038	0.8023
010047	0.7694
010052	0.7670
010061	0.8109
010078	0.8023
010091	0.7613
010109	0.8018
010110	0.7782
010125	0.8043
010128	0.7613
010129	0.7701
010138	0.7633
010146	0.8023
030067	0.9153
040047	0.7633
040067	0.7523
040081	0.7873
050002	1.5354
050007	1.4948
050008	1.4828
050016	1.2055
050043	1.5354
050047	1.4828
050055	1.4828
050070	1.4948
050075	1.5354
050084	1.1942
050113	1.4948
050122	1.1942
050152	1.4828
050167	1.1942
050194	1.5721
050195	1.5354
050211	1.5354
050228	1.4828
050232	1.2055
050242	1.5721
050264	1.5354
050283	1.5354
050289	1.4948
050305	1.5354
050313	1.1942
050320	1.5354
050325	1.1769
050335	1.1769
050336	1.1942

050366	1.1751
050407	1.4828
050444	1.2214
050454	1.4828
050457	1.4828
050488	1.5354
050506	1.2055
050512	1.5354
050633	1.2055
050668	1.4828
050707	1.4948
050714	1.5721
050748	1.1942
050754	1.4948
060010	0.9733
060030	0.9733
100102	0.8858
100290	0.9315
110100	0.8651
110101	0.7928
110142	0.8046
110190	0.8102
110205	0.8368
130024	0.8493
130066	0.9674
130068	0.9674
140001	0.8715
140026	0.8661
140234	0.8661
150015	0.8899
150022	0.8727
150072	0.8674
160013	0.8655
160030	1.0016
160032	0.8711
170150	0.8146
180064	0.8124
180070	0.8050
180079	0.8069
190017	0.7773
190034	0.7775
190044	0.7847
190050	0.7630
190053	0.7687
190054	0.7671
190078	0.7773
190116	0.7671
190133	0.7688
190140	0.7621
190145	0.7676
190190	0.7747
190246	0.7747

190257	0.7647
200032	0.8875
210001	0.9443
210023	1.0110
210028	0.9424
210043	1.0110
220002	1.1488
220011	1.1488
220049	1.1488
220063	1.1488
220070	1.1488
220082	1.1488
220084	1.1488
220098	1.1488
220101	1.1488
220105	1.1488
220171	1.1488
230005	0.9382
230015	0.9204
230075	1.0100
230093	0.8967
230217	1.0100
240018	0.9919
240044	0.9739
240117	0.9641
240211	0.9926
250128	0.8198
250160	0.8198
260059	0.8230
260097	0.8453
260116	0.8240
260163	0.8240
270081	0.8570
280077	0.8927
280123	0.8970
300011	1.1329
300012	1.1329
300020	1.1329
300034	1.1329
310010	1.1709
310011	1.1732
310044	1.1709
310092	1.1709
310110	1.1709
320011	0.9408
320018	0.8990
320085	0.8990
330010	0.8419
330033	0.8575
330047	0.8419
330132	0.8483
330135	1.1625

330175	0.8612
330205	1.1625
330264	1.1625
330276	0.8388
340020	0.8760
340024	0.8781
340037	0.8766
340038	0.8857
340085	0.9107
340096	0.9107
340104	0.8766
340133	0.8912
340151	0.8656
360002	0.8838
360040	0.9084
360044	0.8824
360071	0.8732
360156	0.8816
370023	0.7792
370065	0.7798
370072	0.7960
370083	0.7753
370100	0.7802
370156	0.7823
370169	0.7865
370172	1.4659
370214	0.7823
380029	1.0473
380051	1.0473
380056	1.0473
390008	0.8399
390052	0.8386
390056	0.8375
390110	0.8391
390117	0.8341
390122	0.8392
390125	0.8361
390130	0.8339
390146	0.8361
390150	0.8370
390181	0.8623
390236	0.8342
420019	0.8866
420043	0.8865
420053	0.8743
430008	0.8879
430048	0.8473
430094	0.8473
440007	0.8137
440016	0.8062
440030	0.7974
440031	0.7937

440033	0.7945
440047	0.8256
440051	0.8000
440057	0.7939
440067	0.7974
440070	0.8027
440081	0.7970
440084	0.7943
440109	0.7988
440115	0.8256
440137	0.8656
440153	0.7925
440174	0.8230
440180	0.7945
440181	0.8283
440182	0.8062
450090	0.8848
450144	0.8757
450163	0.8252
450192	0.8469
450194	0.8411
450210	0.8349
450236	0.8587
450270	0.8469
450370	0.8433
450451	0.8734
450460	0.8251
450497	0.8573
450539	0.8265
450547	0.8393
450565	0.8684
450573	0.8324
450641	0.8573
450698	0.8325
450755	0.8474
450838	0.8324
450884	0.8921
450886	0.9661
450888	0.9661
460017	0.8598
490084	0.8261
490110	0.8314
500019	1.0690
510012	0.7692
520035	0.9760
520044	0.9760
520057	0.9877
520096	0.9879

Hospitals Not Receiving Full APU for FY2008

State	Hospital ID
AK	020014
AL	010010
AL	010043
AL	010059
AL	010069
AL	010130
AR	040014
AZ	030071
AZ	030073
AZ	030074
AZ	030077
AZ	030084
AZ	030108
AZ	030113
AZ	030118
AZ	030119
CA	050054
CA	050091
CA	050095
CA	050096
CA	050102
CA	050126
CA	050138
CA	050158
CA	050189
CA	050192
CA	050257
CA	050281
CA	050325
CA	050333
CA	050349
CA	050377
CA	050385
CA	050397
CA	050417
CA	050430
CA	050433
CA	050447
CA	050456
CA	050494
CA	050503
CA	050517
CA	050543
CA	050545
CA	050546
CA	050547
CA	050548
CA	050601
CA	050618
CA	050644
CA	050662

Hospitals Not Receiving Full APU for FY2008

CA	050667
CA	050682
CA	050698
CA	050708
CA	050720
CA	050725
CA	050726
CA	050746
CA	050749
CA	050751
CO	060041
CO	060096
CO	060115
CT	070038
DC	090008
FL	100024
FL	100076
FL	100108
FL	100134
FL	100277
FL	100298
GA	110044
GA	110112
GA	110209
HI	120010
IA	160080
IL	140033
IL	140205
KS	170039
LA	190037
LA	190081
LA	190118
LA	190128
LA	190135
LA	190151
LA	190199
LA	190208
LA	190249
LA	190251
LA	190258
LA	190266
LA	190267
LA	190270
LA	190272
MA	220019
MA	220133
MA	220153
MA	220154
MA	220172
MI	230096
MI	230144
MI	230298

Hospitals Not Receiving Full APU for FY2008

MN	240196
MN	240211
MO	260004
MO	260057
MO	260080
MO	260159
MS	250023
MS	250051
MS	250060
MS	250061
MS	250079
MS	250082
MS	250126
MS	250127
MS	250149
MS	250151
MS	250152
MT	270011
MT	270086
NC	340104
NC	340121
NC	340137
NC	340138
NC	340148
NC	340168
ND	350063
NE	280119
NE	280123
NJ	310039
NJ	310083
NJ	310118
NM	320058
NM	320060
NM	320061
NM	320062
NM	320067
NV	290002
NV	290020
NV	290027
NV	290042
NV	290051
NY	330010
NY	330029
NY	330166
NY	330189
NY	330230
NY	330242
NY	330270
NY	330389
NY	330406
OH	360179
OH	360245

Hospitals Not Receiving Full APU for FY2008

OH	360247
OH	360258
OH	360266
OH	360269
OH	360271
OK	370153
OK	370166
OK	370169
OK	370174
OK	370200
OK	370226
PA	390025
PA	390114
PA	390176
PA	390189
PA	390278
PA	390302
PA	390311
PA	390312
SC	420006
SC	420016
SC	420057
SC	420062
SD	430060
SD	430064
SD	430081
SD	430083
SD	430084
SD	430093
TN	440054
TN	440070
TN	440223
TN	440224
TX	450108
TX	450270
TX	450393
TX	450446
TX	450539
TX	450573
TX	450578
TX	450605
TX	450610
TX	450683
TX	450690
TX	450746
TX	450755
TX	450758
TX	450760
TX	450770
TX	450774
TX	450813
TX	450825

Hospitals Not Receiving Full APU for FY2008

TX	450856
TX	450864
TX	450865
TX	450877
TX	450879
TX	450884
TX	450886
TX	670002
TX	670006
TX	670007
TX	670010
TX	670011
TX	670013
TX	670015
TX	670017
TX	670028
UT	460018
UT	460055
VA	490104
VA	490105
VA	490106
VA	490108
VA	490109
VA	490129
VA	490134
VA	490135
VA	490138
WA	500088
WA	500140
WA	500143
WI	520203
WV	510086

Post Acute Transfer DRGs FY 08

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Post Acute Transfer DRGs FY 08

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Post Acute Transfer DRGs FY 08

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Post Acute Transfer DRGs FY 08

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Post Acute Transfer DRGs FY 08

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Post Acute Transfer DRGs FY 08

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