

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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["General Equivalence Mappings Frequently Asked Questions,"](#) Booklet, ICN 901743, hard copy only.

MLN Matters® Number: MM8421 **Revised**

Related Change Request (CR) #: CR 8421

Related CR Release Date: November 19, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R2819CP

Implementation Date: October 7, 2013

Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Note: This article was revised on November 25, 2013, to reflect changes made to CR 8421 on November 19. In the article, the Total Uncompensated Care Amount is revised and the year in the last sentence of the second paragraph in the Low Volume section is revised. Also, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospitals that submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A Medicare Administrative Contractors (Part A MACs) for acute care and long-term care hospital services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8421 which provides Fiscal Year (FY) 2014 updates to the Acute Care Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

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All items covered in CR8421 are effective for hospital discharges occurring on or after October 1, 2013, unless otherwise noted. See the Background and Additional Information Sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

The policy changes for FY 2014 were displayed in the Federal Register on August 02, 2013, and published on August 19, 2013.

You can find the home page for the FY 2014 Hospital Inpatient PPS final rule at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html> on the Centers for Medicare & Medicaid Services (CMS) website. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to: the final rule (display version or published Federal Register version) and all subsequent published correction notices (if applicable); and includes:

- All tables;
- Additional data and analysis files; and
- The impact file.

Files related to the Long Term Care PPS can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html> on the CMS website.

Key Points of CR8421

IPPS Updates

MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG Grouper, Version 31.0, software package effective for discharges on or after October 1, 2013. The GROUPER 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). Please note the National Uniform Billing Committee (NUBC) approved 15 new patient discharge codes (81-95) adapted after existing codes with “a Planned Acute Care Hospital Inpatient Readmission” appended in the title. A new patient discharge status code 69 was created in order for providers to be able to indicate discharges/transfers to a Designated Disaster Alternative Care Site. The MCE Version 31.0 which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2013.

For discharges occurring on or after October 1, 2013, the Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation in early August 2013.

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For discharges occurring on or after October 1, 2013, the MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation in early August 2013. Note that the version continues to match the Grouper.

Post-acute Transfer and Special Payment Policy

There are no changes to the Post-acute and Special Post-acute payment policy or applicable DRGs for FY 2014. Refer to Table 5 in the IPPS Rule for the list of applicable DRGs.

Please note that the new Patient Status codes (81-95) that refer to “Planned Readmissions” have been mapped to their non-planned readmission counterparts and are included in the transfer policy.

The new patient status code 69 does not impact the transfer policy.

New Technology Add-On

The following items are eligible for new-technology add-on payments in FY 2014:

1. DIFICID- Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is \$868. (For your information the ICD-10-CM diagnosis code is A04.7.)
2. Zenith Fenestrated Graft- Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is \$8,171.50.
(For your information the ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.)
3. Voraxaze- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is \$45,000. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)
4. New for FY 2014 - Argus- Cases involving the Argus ®II System that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 14.81. The maximum add-on payment for a case involving the Argus ®II System is \$72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal

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Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)

5. New for FY 2014 - Kcentra- Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is \$1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32 and D68.4.)
6. New for FY 2014 - Zilver- Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is \$1,705.25. (For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. These adjustments are listed in a table later in this article.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A of CR8421 - Section 505, shows the IPPS providers that will be receiving a "special" wage index for FY 2014 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated.

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes. Later in this article is a list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2014.

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Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under 42 CFR 412.103

An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that 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)). Please reference Table 9C of FY 2014 Final rule.

Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2013. Therefore, beginning in FY 2014, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (We note that, our SCH policy at 42 CFR 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.)

Hospital Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

In FY 2013, Medicare contractors updated the Hospital Specific (HSP) amount for all SCHs to FY 2012 dollars. For FY 2014, the HSP amount will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

In addition, the HSP logic in Pricer has been updated, consistent with the implementation of the statutory changes to the operating DSH payment methodology provided by the provisions of section 3133 of the Affordable Care Act, to include the empirically justified Disproportionate Share Hospital (DSH) payment and the estimated uncompensated care payment in the Federal rate payment amount, if applicable, when comparing the HSP rate payment amount to the Federal rate payment amount.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014

For FYs 2011, 2012, and 2013, the Affordable Care Act, as amended by the American Tax Relief Act, expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2014, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act and the American Tax Relief Act. Therefore, as specified under the regulations at 42 CFR 412.101, effective for FY 2014 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "subsection (d) hospital" and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2014 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

Your FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. For FY 2014 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current

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year (see 42 CFR 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2014 (and subsequent years), a hospital must be located more than 25 road miles (as defined at 412.101(a)) from the nearest "subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/ MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2014, a hospital must meet both the discharge and mileage criteria (set forth at 412.101(b)(2)(i)).

For FY 2014, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2013, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2013 (through September 30, 2014). For requests for low-volume hospital status for FY 2014 received after September 1, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2014 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org> on the Internet. This website was expected to be updated by August 19, 2013. Should a provider later be determined to have met the criteria after publication of this list, they will be added. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2014 under the Hospital Inpatient Quality Reporting (IQR) Program are listed in Attachment C of CR8421- Hospitals Not Receiving Annual Payment Update (APU) - FY 2014. New hospitals are treated as receiving the quality update.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has excluded Maryland hospitals from the Hospital VBP Program for the FY 2014 program year. The

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regulations that implement this provision are in subpart I of 42 CFR part 412 (412.160 through 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2014 is 1.25 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPS and submit requests for corrections to the information before it is made public.

For FY 2014 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2014. Note that the values listed in Table 16A of the IPPS Final Rule are "proxy" values. The proxy values are not used to adjust payments. The IPPS PRICER will display the VBP payment amount in a new output field.

Hospital Readmissions Reduction Program

For FY 2014, the readmissions adjustment factor is the higher of a ratio or 0.98 (-2 percent). The readmission adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2014 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2014, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9800.

The Hospital Readmissions Reduction Program adjustment factors for FY 2014 can be found in Table 15 of the FY 2014 IPPS final rule, which is available at <http://www.cms.gov/Medicare/Medicare->

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[Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending](#) on the CMS website.

Note: Although Maryland hospitals are exempt from the payment adjustment under the Hospital Readmissions Reduction Program for FY 2014, a readmissions adjustment factor of 1.0000 (that is no adjustment) is shown for Maryland hospitals in Table 15. Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program and therefore are not listed in Table 15.

The IPPS PRICER will display the HRR payment amount in a new output field.

Recalled Devices

As a reminder, Section 2202.4 of the "Provider Reimbursement Manual, Part I" states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled Payments for Care Improvement Initiative (BPCI)

Model 1 - CMS is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative. In Model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model propose a discount percentage which will be applied to payment for all participating hospitals' Diagnosis Related Groups (DRG) over the lifetime of the initiative. Participating hospitals may gainshare with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at <http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html> on the Internet.

For hospitals participating in Model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG, IME, DSH, and outlier payments will be calculated based on the nondiscounted base payments. PRICER will display the Model 1 payment amount in a new output field.

Internally, the claims processing system will convert the Model 1 participating indicator '1' to a demo code '61' which will trigger PRICER to perform the payment calculation using the discount percentage. **Model 1 demonstration code '61' is for internal use only and shall not be entered by providers.**

Provider Specific File (PSF)

The PSF-required data elements for all provider types which require a PSF can be found in the "Medicare Claims Processing Manual," Chapter 3, Section 20.2.3.1 and Addendum A. FIs/MACs will update the Inpatient PSF for each hospital as needed, but they must update all applicable fields for IPPS hospitals effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report. Pricer requires a PSF record with a 10/1 effective date.

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Tables 8a and 8b contain the FY 2014 Statewide average operating and capital cost-to-charge ratios, respectively. Tables 8a and 8b are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html> on the CMS website. On the left side select FY 2014 IPPS Final Rule Home Page and then select FY 2014 Final Rule Tables.

Per the regulations at 42 CFR 412.84(i)(3), for FY 2014, statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18). 2. Hospitals whose operating CCR is in excess 1.186 or capital CCR is in excess of 0.173 (referred to as the operating CCR ceiling and capital CCR ceiling, respectively). 3. Hospitals for which the FI or MAC is unable to obtain accurate data with which to calculate an operating and/or capital CCR. Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2 of chapter 3 of the claims processing manual. Provider Types (PSF data element 9) 14 and 15 are no longer valid beginning in FY 2014 (with the expiration of the MDH program as noted above). FIs/MACs shall determine the appropriate provider type and update the PSF accordingly with an effective date of October 1, 2013.

Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

For FY 2014, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is \$9,044,632,555.68, as calculated as the product of 75 percent of Medicare DSH (estimated by the CMS' Office of the Actuary) and the change in percent of uninsured individuals at 94.3 percent. The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2014 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2014. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2010-2012). The estimated per discharge uncompensated care payment amount will be in a Table in

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PRICER and that dollar amount will be added to each claim for FY 2014. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations, and will be included as a federal payment in the comparison for Sole Community Hospitals to determine if a claim is paid under the hospital specific rate or federal rate. The total uncompensated care payment amount finalized in the FY 2014 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis. The IPPS PRICER will display the uncompensated care payment amount in a new output field.

LTCH PPS FY 2013 Update

FY 2014 LTCH PPS Rates and Factors are located in a table just before the "Additional Information" section near the end of this article. The LTCH PPS Pricer has been updated with the Version 31.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2013, and on or before September 30, 2014.

LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. Beginning in FY 2014, the annual update to a standard Federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

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" Chapter 3, Section 20.2.3.1 and Addendum A. FIs/MACs will update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8c contains the FY 2014 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments. Table 8c is available on the internet at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1599-F.html> on the CMS website. Per the regulations in 42 CFR 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2014, Statewide average CCRs are used in the following instances: 1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR Section 489.18). 2. LTCHs with a total CCR is in excess of 1.305 (referred to as the total CCR ceiling). 3. Any hospital for which data to calculate a CCR is not available. Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the claims processing manual.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The applicable COLAs that are effective for discharges occurring on or after October 1, 2013 established in the FY 2014 IPPS/LTCH PPS final rule, are shown in the tables section later in this article.

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Core-Based Statistical Area (CBSA)-based Labor Market Area Updates

There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2014. The CBSAs definitions and codes that will continue to be effective October 1, 2013 can be found in Table 12A listed in the Addendum of the FY 2014 IPPS/LTCH PPS final rule, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html> on the CMS website.

Additional LTCH PPS Policy Changes for FY 2014

The moratoria on the full implementation of the “25 percent threshold” payment adjustment will expire for LTCH cost reporting periods beginning on or after October 1, 2013. The 5 year statutory moratorium which expired for cost reporting periods beginning on or after July 1 or October 1, 2012, as applicable, was followed by regulatory moratoria that generally maintained the existing policies for both “July” and “October” LTCHs. For additional details, see to the discussion in the FY 2014 IPPS/LTCH PPS final rule. In addition, the short-stay outlier (SSO) logic in the PRICER was updated to reflect the implementation of the statutory changes to the IPPS operating DSH payment methodology per by the provisions of section 3133 of the Affordable Care Act in the calculation of “an amount comparable to the IPPS per diem amount” under the 4th option in the SSO payment formula.

Tables from CR8421**FY 2014 IPPS Rates and Factors**

Standardized Amount Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Hospital Specific Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Common Fixed Loss Cost Outlier Threshold	\$21,748.00
Federal Capital Rate	\$429.31
Puerto Rico Capital Rate	\$209.82
Outlier Offset-Operating National	0.948995
Outlier Offset-Operating Puerto Rico	0.943455
SCH Budget Neutrality Factor	0.997989
SCH Documentation and Coding Adjustment Factor	0.9480
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A	0.998

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Operating Rates

Rates with Full Market Basket and Wage Index > 1	Rate
National Labor Share	\$3,737.71
National Non Labor Share	\$1,632.57
PR National Labor Share	\$3,737.71
PR National Non Labor Share	\$1,632.57
Puerto Rico Specific Labor Share	\$1,608.90
Puerto Rico Specific Non Labor Share	\$936.82

Rates with Full Market Basket and Wage Index < or = 1	Rate
National Labor Share	\$3,329.57
National Non Labor Share	\$2,040.71
PR National Labor Share	\$3,329.57
PR National Non Labor Share	\$2,040.71
Puerto Rico Specific Labor Share	\$1,578.35
Puerto Rico Specific Non Labor Share	\$967.37

Rates with Reduced Market Basket and Wage Index > 1	Rate
National Labor Share	\$3,664.21
National Non Labor Share	\$1,600.46
PR National Labor Share	\$3,737.71
PR National Non Labor Share	\$1,632.57
Puerto Rico Specific Labor Share	\$1,608.90
Puerto Rico Specific Non Labor Share	\$936.82

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Rates with Reduced Market Basket and Wage Index < or = 1	Rate
National and PR National Labor Share	\$3,264.10
National and PR National Non Labor Share	\$2,000.57
PR National Labor Share	\$3,329.57
PR National Non Labor Share	\$2,040.71
Puerto Rico Specific Labor Share	\$1,578.35
Puerto Rico Specific Non Labor Share	\$967.37

FY 2014 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	1.23
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
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Hospitals Waiving Lugar Redesignation for the Out-Migration Adjustment

Medicare CCN	Provider Name
070021	WINDHAM COMM MEM HOSP & HATCH HOSP
250117	HIGHLAND COMMUNITY HOSPITAL
390031	SCHUYLKILL MEDICAL CENTER - EAST NORWEGIAN STREET
390150	SOUTHWEST REGIONAL MEDICAL CENTER
390201	POCONO MEDICAL CENTER

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Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs)

Hospital Specific Applicable Percentage Increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
SCH Budget Neutrality Factor	0.997989
SCH Documentation and Coding Adjustment Factor	0.9480
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A	0.998

FY 2014 LTCH PPS Rates and Factors

Federal Rate for discharges from 10/1/13 through 09/30/14	New beginning in FY 2014, rate based on successful reporting of quality data. <ul style="list-style-type: none"> • Full update (quality indicator on PSF = 1): \$ 40,607.31 • Reduced update (quality indicator on PSF = 0 or blank): \$ 39,808.74
Labor Share	62.537%
Non Labor Share	37.463%
High Cost Outlier Fixed-Loss Amount	\$13,314

Additional Information

The official instruction, CR8421 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2819CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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