Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-03-073 **Date: AUGUST 22, 2003**

CHANGE REQUEST 2891

SUBJECT: Fiscal Year (FY) 2004 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH), and Other Bill Processing Changes

I. GENERAL INFORMATION

A. Background: This Program Memorandum (PM) outlines changes for IPPS hospitals for FY 2004. The changes for FY 2004 were published in the **Federal Register** on August 1, 2003. All items covered in this PM are effective for hospital discharges occurring on or after October 1, 2003, unless otherwise noted. This PM also addresses new Grouper and DRG changes that are effective October 1, 2003 for hospitals paid under the LTCH PPS. LTCH PPS rate changes occurred on July 1, 2003. See PM A-03-056 published on June 27, 2003.

B. Policy:

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2003. The new ICD-9-CM codes are listed, along with their diagnosis-related group (DRG) classifications in Tables 6a and 6b of the August 1, 2003 **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 The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d.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.

GROUPER 21.0 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, 2003. Medicare Code Editor (MCE) 20.0 and Outpatient Code Editor (OCE) versions 19.0 and 4.3 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2003.

Furnished Software Changes

The following software programs were issued for FY 2004:

A. **IPPS PRICER 04.0** for discharges occurring on or after October 1, 2003. This processes bills with discharge dates on or after October 1, 1999. The IPPS Pricer was released to the maintainers on August 14, 2003.

1. Rates

Standardized Amount Update Factor	3.4%
Hospital Specific Update Factor	3.4%
National Adjusted Operating Standardized Amounts, Labor/Nonlabor	Large Urban: Labor=$3,146.06 Nonlabor=$1,278.78 Other Area: Labor=$3,096.25 Nonlabor=$1,258.54

Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor	National/Large Urban: Labor=$3,119.61 Nonlabor=$1,268.03 National/Other Area: Labor=$3,119.61 Nonlabor=$1,268.03 PR/Large Urban: Labor=$1,510.12 Nonlabor=$607.86 PR/Other Area: Labor=$1,486.22 PR/Other: Nonlabor=$598.24
Common Fixed Loss Cost Outlier Threshold	$31,000.00
Federal Capital Rate	$415.47
Puerto Rico Capital Rate	$203.15
Outlier Offset-Operating National	0.949236
Outlier Offset-Operating Puerto Rico	0.976658
Outlier Offset-Operating National PR blend	0.962947
IME Formula	1.35*[(1+ resident-to-bed ratio)**. 405-1]
MDH/SCH Budget Neutrality Factor	1.005522

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the August 1, 2003 **Federal Register**.

NOTE: It has come to our attention that some wage indices are incorrect in the August 1, 2003 **Federal Register**. A correction notice to the **Federal Register** will be issued shortly.

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy which paid as transfers all cases which assigned to one of 10 DRGs if the patient is discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a long term care hospital, a children's hospital, a cancer hospital, a skilled nursing facility, or a home health agency. Those DRGs were 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

Effective for discharges on or after October 1, 2003, the postacute care transfer policy is expanded, adding 21 additional DRGs to the original 10. They are: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.

DRGs 263 and 264 are deleted from the original 10 DRG list and will no longer be subject to this transfer policy effective October 1, 2003.

3**.** New Technology Add-On Payment

Hospitals providing InFUSE™ are eligible for a new technology add-on payment effective for discharges on or after October 1, 2003. Under 42 CRF 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education, disproportionate share, transfers, etc., but excluding outlier payments.) Pricer will calculate the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for the eligible cases will be equal to:

--The DRG payment, plus

--The lesser of
1. 50 percent of the costs of the new medical service or technology; or
2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment; plus

--Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

Pricer will calculate InFUSE™ in the same way it calculates Xigris™ (identified by procedure code 00.11). In order to pay the add-on technology payment for InFUSE™, Pricer will look for the presence of two ICD-9-CM procedure codes, 84.51 and 84.52. If both are present, Pricer will calculate the new technology add-on only if the case groups to DRG 497 or 498. The maximum add-on payment for InFUSE™ is $8900.00.

It is possible to have both new technologies on the same claim. Should both new technologies be present, Pricer will calculate Xigris™ and then calculate InFUSE™, summing the two new technology payments. The total is in the field labeled "PPS-New-Tech-Payment-Add-On" returned from Pricer.

B. **Grouper 21.0** for discharges occurring on or after October 1, 2003. PRICER calls the appropriate Grouper based on discharge date. Medicare contractors will receive the Grouper documentation on or about August 1, 2003.

C. **MCE 20.0** for discharges occurring on or after October 1, 2003, and OCE 19.0 and 4.3 for services furnished on or after October 1, 2003. These replace earlier versions and contain complete tables driven by date. The MCE and OCE select the proper internal tables based on discharge date. Medicare contractors will receive the MCE documentation on or about August 1, 2003.

ICD-9-CM Procedure Codes V53.01 and V53.02 should not be included in the "Unacceptable Principle Diagnosis" Edit. FIs shall manually override the "Unacceptable Principle Diagnosis" edit in the MCE for these two codes effective for discharges on or after October 1, 2003 until the MCE is corrected.

The MCE has seven new edits, called limited coverage edits. These procedures were previously in the non-covered procedures list, but were covered under limited circumstances. The new edits will make it easier for the FI to distinguish these services in order to override them when appropriate. FIs should continue to research and work these as they had when they were in the non-covered procedure list.

MCE Edit Description	Procedure Code	Short Description
LVRS-Limited Coverage	3222	Lung vol reduction surg
Lung Transplant-Limited Coverage	3350	Lung transplant NOS
	3351	Unilat lung transplant
	3352	Bilat lung transplant
Combo Heart/Lung Transpl-Limit Cov	336	Comb heart/lung transpla
Heart Transplant-Limited Coverage	3751	Heart Transplantation
Imp imp pul hrt asst sys-Limit Cov	3766	Imp imp pul hrt asst sys
Intest/M.Visceral Transpl-Limit Cov	4697	Transplant of intestine
Liver Transplant-Limited Coverage	5059	Liver transplant NEC

D. LTCH Pricer-LTC-DRGs and Relative Weights:

The annual update of the LTC-DRGs, relative weights and GROUPER software for FY 2004 are published in the annual IPPS final rule. The same GROUPER software developed by 3M for the Hospital Inpatient PPS will be used for the LTCH PPS. The LTCH Pricer was released to the maintainers on August 14, 2003.

- Version 21.0 of the Hospital Inpatient PPS GROUPER will be used for FY 2004, but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

- The annual update of the LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay (for short-stay outlier cases) for FY 2004 was determined using the most recent available LTCH claims data (FY 2002).

- The LTC-DRGs, relative weights, (geometric) average length of stay and 5/6th of the average length of stay effective for discharges on or after October 1, 2003 can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

Provider Specific File

Update the provider IPPS (PROV) file for each hospital as needed, effective October 1, 2003, and effective with the cost reporting period that begins on or after October 1, 2003. At a minimum, update the following fields:

- 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;
- Change code for wage index reclassification: Enter "N" if a hospital has not been reclassified for Federal FY 2004, or a "Y" if it has;
- If a hospital has been reclassified for FY 2004, update the wage index and standardized amount location Metropolitan Statistical Areas (MSAs);
- 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 a hospital is no longer in its first 2 years of operation;
- Capital indirect medical education ratio; and
- Capital exception payment rate (as applicable).

REMINDER for LTCH PROV files: Update the Fiscal Year Begin date field. The LTCH Pricer cannot pull the 2/5th wage index if the FYB date is not updated. For all other required fields for the provider specific file see Medicare Intermediary Manual, Part III Claims Process, Section 3850 (http://cms.hhs.gov/manuals/13_int/a3850.asp#_3850_0).

- Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2004 statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when you are unable to compute a hospital-specific cost-to-charge ratio within the following ranges. Also see Transmittal A-03-058.

- MSA reclassifications--Enter standardized amount and wage index reclassifications issued by the Medicare Geographic Classification Review Board effective October 1, 2003, into the Provider Specific File. Actual geographic location MSA data is found in file positions 59-62 of the PSF. Use file positions 63-66 to record any wage index location MSA to which a hospital was reassigned. Record the standardized amount location MSA to which a hospital was reassigned in file positions 67-70. Enter a "Y" in file position 58 if there was a wage index reclassification for FY 2003, or an "N" if there was not a reclassification. Enter an "N" for providers with an entry in the "hold harmless" column. If a provider is reclassified for standardized amount to an MSA in a different census division, change the census division in the PROV file to match the new MSA.

Other Changes

A. Transfers under IPPS

Claims coded as Left Against Medical Advice (LAMA) with patient status code 07 will now be treated as transfers if the patient is subsequently admitted to another IPPS hospital on the same day. This will require systems changes to the standard systems and the Common Working File and will not be implemented until April 1, 2004. We will issue detailed instructions shortly. Providers should code LAMAs with a patient status code 02 if the patient is admitted to another IPPS hospital on the same day.

B. LTCH PPS Cost-To-Charge Ratios

To ensure that the distribution of outlier payments remains equitable, for FY 2004 a LTCH's overall Medicare cost-to-charge ratio is considered not to be reasonable if the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. Effective for discharges occurring on or after October 1, 2003, the combined operating and capital upper limit (ceiling) on cost-to-charge ratios is 1.366 (1.203 plus 0.163). If the overall Medicare cost-to-charge ratio appears not to be reasonable, the fiscal intermediary should ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average. The appropriate (combined) statewide average cost-to-charge ratios for FY 2004 can be found in Tables 8A and 8B of the IPPS Final Rule.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
2891.1	Medicare Contractors shall install IPPS and LTCH Pricers with the implementation of the October quarterly release.	FISS/APASS/ FIs
2891.2	Medicare Contractors shall install the MCE and Grouper software with the implementation of the October quarterly release.	FISS/APASS/ FIs
2891.2.1	Standard systems shall create edits to coincide with the new limited coverage edits given by the MCE.	FISS/APASS
2891.2.2	Standard systems shall allow these edits to have the capacity to be overridden by the fiscal intermediary (FI).	FISS/APASS
2891.2.3	FIs shall suspend claims that hit the new Limited Coverage edits in the MCE and research those claims as before.	FIs
2891.2.4	FIs shall override the MCE edit if coverage conditions are met per existing coverage guidelines.	FIs
2891.2.5	FIs shall reject claims if coverage conditions are not met.	FIs
2891.2.6	FIs shall override the "unacceptable principle diagnosis" edit in the MCE for ICD-9-CM procedure codes V53.01 and V53.02.	FIs

2891.3	FIs shall update the provider specific files for every PPS hospital. (See section B-III of this PM).	FIs
2891.4	FIs shall inform affected providers by posting relevant portions of this instruction on their websites within two weeks of the issuance date of this instruction. In addition, this same information shall be published in you next regularly scheduled bulletin. If you have a listserv that targets the affected providers, you must notify subscribers that information about "FY 04 IPPS and LTCH PPS Bill Processing Changes" is available on your website.	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: Pricer, MCE, and Grouper

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: This instruction is dependent on publication of the August 1, 2003 IPPS Final Rule.

F. Testing Considerations: At a minimum contractors should test: 1. Claims with Xigris™ and InFUSE™, Xigris™ only and InFUSE™ only, 2. DRGs in expanded postacute care transfer policy, 3. New MCE edits.

IV. ATTACHMENT(S): N/A

Version: August 21, 2003 Implementation Date: October 1, 2003 Discard Date: September 30, 2004 Post-Implementation Contact: Regional Office	Effective Date: October 1, 2003 Funding: These instructions should be implemented within your current operating budget. Pre-Implementation Contact: Sarah Shirey