CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 309 **Date: October 1, 2004**

CHANGE REQUEST 3459

SUBJECT: Fiscal Year (FY) 2005 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) and Other Bill Processing Changes Related to the IPPS Final Rule

I. SUMMARY OF CHANGES: This CR outlines some important policies in the IPPS Final Rule affecting the Pricer Program and Provider Specific Files. These include, New Tech Add-ons, Postacute Care Diagnosis Related Groups, Core Based Statistical Areas, Hospital Quality Initiative, Low Volume Hospitals, LTCH Hospital within Hospital, and other changes related to capital payments.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: October 4, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
X	Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 309	Date: October 1, 2004	Change Request 3459

SUBJECT: **Fiscal Year (FY) 2005 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH), and Other Bill Processing Changes**

I. GENERAL INFORMATION

A. Background: This change request (CR) outlines changes for IPPS hospitals for FY 2005. The changes for FY 2005 were published in the **Federal Register** on August 11, 2004. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2004, unless otherwise noted.

This CR also addresses new Grouper and DRG changes that are effective October 1, 2004 for hospitals paid under the LTCH PPS. LTCH PPS rate changes occurred on July 1, 2004. Please refer to Transmittal 208, published on June 18, 2004, Transmittal 240, published on July 23, 2004, and Transmittal 267, published on July 30, 2004 for LTCH policy changes.

B. Policy:

ICD-9-CM Changes

ICD-9-CM coding changes are effective October 1, 2004. The new ICD-9-CM codes are listed, along with their diagnosis-related group (DRG) classifications in Tables 6a and 6b of the August 11, 2004 **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 22.0 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, 2004. Medicare Code Editor (MCE) 21.0 and Outpatient Code Editor (OCE) versions 20.0 and 5.3 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2004.

Furnished Software Changes

The following software programs were issued for FY 2005:

A. IPPS PRICER 05.0 for discharges occurring on or after October 1, 2004. This processes bills with discharge dates on or after October 1, 2000. Rates were published in the August 11, 2004 Federal Register, however these are the new rates.

1. Rates

Standardized Amount Update Factor	1.033
Hospital Specific Update Factor	1.033
Common Fixed Loss Cost Outlier Threshold	$25800.00
Federal Capital Rate	$416.53
Puerto Rico Capital Rate	$199.01
Outlier Offset-Operating National	0.948978
Outlier Offset-Operating Puerto Rico	0.973183

Outlier Offset-Operating National PR blend	0.955029
IME Formula	1.42*[1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor *	0.999876

* Replace the 2004 update with 1.002608 (average of FY 2004).

Quality = 1 / Wage Index > 1 — **Full Update and .711 Labor Share**

	Labor Share	Non-Labor Share
National	3238.07	1316.18
PR National	3238.07	1316.18
PR Specific	1,554.79	625.84

Quality <> 1 / Wage Index > 1 — **Lower Update and .711 Labor Share**

	Labor Share	Non-Labor Share
National	3225.53	1311.08
PR National	3225.53	1311.08
PR Specific	1548.77	623.42

Quality = 1 / Wage Index <= 1 — **Full Update and .62 Labor Share**

	Labor Share	Non-Labor Share
National	2823.64	1730.62
PR National	2823.64	1730.62
PR Specific	1351.99	828.64

Quality <> 1 / Wage Index <= 1 — **Lower Update and .62 Labor Share**

	Labor Share	Non-Labor Share
National	2812.70	1723.91
PR National	2812.70	1723.91
PR Specific	1346.76	825.43

The revised hospital wage indices and geographic adjustment factors are contained in Tables 4a2 (urban areas), 4b2 (rural areas) and 4c2 (redesignated hospitals) of the August 11, 2004 **Federal Register**.

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. On October 1, 2003, that list was expanded to 29 DRGs..

Effective for discharges on or after October 1, 2004, we are adding two more DRGs to this list: 541 and 542 and we are removing 483 from the list.

3. New Technology Add-On Payment

Effective for discharges on or after October 1, 2004, there are three "new" new technology add-on payments, the OP-1 Implant, CRT-D and Kinetra®, in addition to InFUSE™, which was effective October 1, 2003. Xigris is no longer included. 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 operating 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.

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 and the ABSENCE of 81.05, 81.08, 81.35, or 81.38. If both codes 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 $1,955.00.

In order to pay the add-on technology payment for OP-1, Pricer will look for the presence of ICD-9-CM procedure codes 84.52, and at least ONE of the following: 81.05, 81.08, 81.35, or 81.38. The DRG must also be 497 or 498. The maximum add-on payment for OP-1 is $1,955.00.

In order to pay the add-on technology payment for CRT-D, Pricer will look for the presence of ICD-9-CM procedure code 00.51 OR 00.54. The maximum add-on payment for CRT-D is $16,262.50.

In order to pay the add-on technology payment for Kinetra®, Pricer will look for the presence of ICD-9-CM procedure codes 02.93 AND 86.95. The maximum add-on payment is $8,285.00.

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

B. Grouper 22.0 for discharges occurring on or after October 1, 2004. PRICER calls the appropriate Grouper based on discharge date. Medicare contractors should have received the Grouper documentation on or about August 4, 2004.

C. MCE 21.0 for discharges occurring on or after October 1, 2004, and OCE 20.0 and 5.3 for services furnished on or after October 1, 2004. 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 should have received the MCE documentation on or about August 4, 2004.

D. Provider Specific File (PSF)

Due to the volume of changes required this FY, we are extending the deadline for FIs to submit the October 1 PSF to CMS 14 days beyond the normal due date.

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, Section 20.2.31 and Addendum or CR 3272.

Due to new Core-based Statistical Area (CBSA) requirements (as discussed in Transmittal 152, published on April 30, 2004), every IPPS hospital's file must be updated effective October 1, 2004. We are providing an attachment to assist you in determining the new CBSA for most, but not all providers. Please see Attachment 2 for a list of most providers and their CBSA. For providers not listed, use the

provider's state and county to locate the CBSA using the Federal Register. If the listed CBSA appears to be incorrect, determine the correct CBSA and code it into the PSF.

NOTE: Attachment 2 has numerous pages, so FIs might want to only print their providers.

NOTE: LTCHs are not subject to the CBSA requirements at this time; LTCHs will continue to use the existing MSA definitions.

Update the provider IPPS (PROV) file for each hospital as needed, and update the following fields for IPPS hospitals effective October 1, 2004 or effective with the cost reporting period that begins on or after October 1, 2004 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 a hospital has been reclassified for FY 2005, 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; and
- 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.):
- Reset the Temporary Relief Indicator to a blank unless this is a "low volume" hospital (see 2 below)
- Enter "1" in the Hospital Quality Indicator field if applicable

Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2005 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 threshold is 1.240 and the capital threshold is 0.169.

1. CBSA Designations, Hospitals with a Blended Wage Index, and Low Volume Hospitals

Use the following sequence to avoid PSF edits during data entry:

Step 1: Enter the actual geographic location CBSA for all inpatient acute care hospitals in file positions 140-144 (Actual Geographic Location CBSA) of the PSF.

Step2: See Attachment 1 for providers that require a Special Wage Index (file position 155-160). This attachment includes blended wage indexes, hold harmless wage indexes, and other special wage index exceptions. The out commuting adjustment to wage indexes only applies if there is no reclassification or other special exception. Where applicable, the out commuting adjustment has already been added to the wage index shown in the special wage index column. Use the special wage index column to determine the proper wage index to be entered into the PSF for all providers listed as well as a 1 in the Special Payment Indicator field (file position 138) or a 2 if the provider is also reclassified. See column L in the attachment. This list includes corrections to the Final Rule expected to be posted to the CMS website shortly.

Step 3: IF the provider does NOT have a Special Wage Index entry per Attachment 1 (step 2 above), enter CBSA wage index reclassifications (Table 9a2 and 9b) issued by the Medicare Geographic Classification Review Board effective October 1, 2004, into the PSF into file positions 145-149 (Wage Index Location CBSA) of the PSF. Enter a "Y" in file position 138 (Special Payment Indicator) if there was a wage index reclassification for FY 2005. If the provider does have a Special Wage Index entry, do not make any entry in the Reclassified Wage Index field.

NOTE: Attachment 1 is more than 30 pages long when printed. The down arrow in cell B1 will allow you to print less pages by filtering for providers by their state code.

2. Low Volume Hospitals

FIs shall enter a “Y” in position 74 (Temporary Relief Indicator) if the hospital is considered “low volume”. If you have this field already set to “Y” because of temporary relief, reset to a blank and only set to “Y” if the hospital is “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. The final rule identifies the process for FIs to know which hospitals are low volume on page 49101. Providers shall notify FIs if they believe they are a low volume hospital.

3. Hospital Quality Initiative

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.qnetexchange.org. Please select ‘HDC’, then ‘List of Providers’ under the heading ‘Reporting Hospital Quality Data for Annual Payment Update’ or ‘What’s New’. Verify the coding for this field in the PSF on or about October 1, 2004.

The list below contains the providers not receiving the quality initiative. Should a provider 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.

Leave the Hospital Quality Indicator blank for the following providers.
Enter a "1" in this field for all other providers.

020019	050137	050541	050681	110056	220172	340168	440166
020021	050138	050545	050686	110193	230283	360258	450123
030084	050139	050546	050690	110221	240205	360263	450270
030109	050140	050548	050698	110222	280200	390275	450393
050071	050392	050561	050710	110224	300015	390287	450534
050072	050397	050604	050713	140205	330402	390302	450648
050073	050411	050609	050723	160107	340007	390305	500134
050076	050425	050662	070038	160118	340104	390306	500140
050095	050512	050674	100134	190110	340137	400122	
050117	050515	050677	100271	220153	340138	440040	

E. Other Changes

Disproportionate Share (DSH) Adjustment for Urban to Rural Providers

42 CFR 412.102 provides for a transition to a rural payment amount from an urban payment amount under the operating PPS over two years. There are a few hospitals with a DSH adjustment near or greater than .12 (the cap on the operating DSH adjustment for certain groups of providers) that were considered urban under the MSA definition, but are now considered rural under the CBSA definition. These providers shall receive an adjustment to their operating DSH payment over the next two years and have been coded into the Pricer in an attempt to most closely approximate the DSH payment they will receive upon cost report settlement. The adjustment gives these hospitals 2/3 of the difference between the urban and rural operating DSH for FY 05 and 1/3 of the difference between the urban and rural operating DSH for FY 06. If an FI determines that a hospital should be added to or removed from this list, they should email Sbarranco@cms.hhs.gov to have the Pricer updated prior to the next release. Based on the best available data, we have identified the following providers:

180049	190191	370016
190044	330047	370149
190144	340085	420043

Capital PPS Payments to Hospitals Located in Puerto Rico

Currently, §412.374 of the regulations provide that capital PPS payments to hospitals located in Puerto Rico are based on a blend of 50 percent of the capital Federal rate (derived from the costs of all acute care hospitals participating in the IPPS, including those located in Puerto Rico) and 50 percent of the Puerto Rico capital rate (derived from the costs of Puerto Rico acute care hospitals only). In the August 11, 2004 IPPS final rule, we revised §412.374 of the regulations to provide that, for discharges occurring on or after October 1, 2004, capital PPS payments to hospitals located in Puerto Rico will be based on a blend of 75 percent of the capital Federal rate and 25 percent of the Puerto Rico capital rate. This change parallels the change in payments to Puerto Rico hospitals under the operating PPS provided for by section 504 of Pub. L. 108-173 for discharges occurring on or after October 1, 2004, which increases the national portion of the operating PPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating PPS payments from 50 percent to 25 percent.

Capital PPS Payments to Hospitals Previously Reclassified for the Operating PPS Standardized Amounts

Previously, the standardized amounts varied under the operating PPS based on a hospital's geographic location (large urban versus other urban and rural areas). In addition, previously, a hospital could be reclassified to a large urban area by the MGCRB for the purpose of the standardized amount if certain criteria were met. Also, in the past, if a rural or other urban hospital was reclassified to a large urban area for purposes of the operating PPS standardized amount, under the capital PPS the hospital was also eligible for a large urban add-on payment under §421.316, as well as a DSH payment adjustment under §412.320.

With the permanent equalization of the operating PPS standardized amounts provided for by various pieces of legislation (Public Laws 108-7, 108-89 and 108-173), all hospitals are now paid based on the large urban standardized amount, regardless of geographic location or MGCRB redesignation. Because

there are no longer differences in standardized amounts due to geographic classification as a result of this legislation, hospitals are not eligible to reclassify solely for standardized amount purposes. Accordingly, the MGCRB denied all FY 2005 standardized amount reclassification requests.

In the August 11, 2004 IPPS final rule, we explained that because of the changes to the operating PPS described above, rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the capital PPS because they reclassified to a large urban area for the purpose of the standardized amount under the operating PPS, are no longer able to reclassify, and therefore, will not be eligible to receive those additional capital PPS payment adjustments beginning in FY 2005. For discharges occurring on or after October 1, 2004, only hospitals geographically located in a large urban area (as defined in §412.63(c)(6)) are eligible for large urban add-on payments provided for under §412.312(b)(2)(ii) and §412.316(b). Similarly, for discharges occurring on or after October 1, 2004, only hospitals serving low-income patients that are geographically located in an urban area (as defined in §412.64) and that meet all other requirements of §412.320 will be eligible for capital PPS DSH payments provided for under §412.320.

Geographic Classification and Definition of Large Urban Area under the Capital PPS

Currently, under the capital PPS the large urban location adjustment provided for under §412.316(b) and the DSH payment adjustment for certain urban hospitals provided for under §412.320 are based on the existing geographic classifications set forth at §412.63. Beginning in FY 2005 and thereafter, a hospital's geographic classification (MSA) will be based on OMB's new CBSA designations, as set forth under new §412.64. Because of this change in the MSA definitions (under new §412.64), we have revised §412.316(b) and §412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the large urban location adjustment (412.316(b)) and the DSH payment adjustment (§412.320) will be based on the geographic classifications at §412.64.

A large urban area is defined at §412.63(c)(6) as an MSA with a population of more than 1,000,000 or a NECMA with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census. Beginning in FY 2005, based on the new MSA definitions established under §412.64 and the 2000 Census data, there are a total of 62 large urban areas, which are denoted in Tables $4A_2$ and $4B_2$ in the Addendum of the August 11, 2004 IPPS final rule. In that same final rule, we revised §§412.312(b)(2)(ii) and 412.316(b) to clarify that for discharges occurring on or after October 1, 2004, the definition of large urban area set forth at §412.63(c)(6) continues to be in effect under the capital PPS for the large urban add-on adjustment

F. LTCH Changes

LTCH PPS Cost-To-Charge Ratios

To ensure that the distribution of outlier payments remains equitable, for FY 2005 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, 2004, the combined operating and capital upper limit (ceiling) on cost-to-charge ratios is 1.409 (1.240 plus 0.169). 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 2005 can be found in Tables 8A and 8B of the IPPS Final Rule.

LTCH Pricer, DRGs, and Relative Weights

The annual update of the LTC-DRGs, relative weights and GROUPER software for FY 2005 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 maintainer on August 17, 2004.

- Version 22.0 of the Hospital Inpatient PPS GROUPER will be used for FY 2005, 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 2005 was determined using the most recent available LTCH claims data (FY 2003).

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, 2004 can be found in Table 11 of this final rule and are in the LTCH PPS PRICER program.

REMINDER for LTCH PROV files: At a minimum, update the Fiscal Year Begin date field. The LTCH Pricer cannot pull the 3/5th wage index if the FYB date is not updated. LTCH PSFs are not required to be updated with CBSAs at this time; LTCHs will continue to use the existing MSA definitions.

LTCH Hospital within Hospital Provision

Effective for discharges from long-term care hospitals as described in §412.23(e)(2)(i) meeting the criteria in §412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in §412.22(h), we have finalized the following revisions to separateness and control regulations at 412.22(e) and added new payment policy regulation at 412.534 for cost reporting periods beginning on or after October 1, 2004.

- The policies will also be applicable if the host hospital is a hospital other than an acute care hospital but only applicable if the HwH is a LTCH.
-
- For existing LTCH HwHs, the 3 performance of basic hospital functions qualifications for HwHs at 412.22(e)(5) (i), (ii), and (iii) are eliminated for cost reporting periods beginning on or after October 1, 2004. (Note provisions of “hold harmless year 10/1/04 – 10/1/05 below)
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- If a LTCH HwH meets existing separateness and control of administrative and medical governance provisions at 412.22(e)(1) through (e)(4), payment will be made under the LTCH PPS as specified in 412.534.

Basic Payment Formula—Please note the new regulations at 42 CFR 412.534 limit the relevant percentage of patients to only Medicare patients.

- Under 412.534, if a LTCH HwH’s admissions from its host hospital exceed 25 percent (or the applicable percentage) of its discharges for the HwH’s cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH

PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS (including capital, DSH, IME, outliers, etc.).

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

Specific Circumstances

- For rural acute care hospitals with HwHs, instead of the 25 percent criterion, the majority, (i.e., at least 51 percent) of the patients would have to be from the hospitals other than the host. In addition, in determining the percentage of patients admitted from the host, any patient that had been Medicare outliers at the host and then transferred to the HwH would be considered as if they were admitted from a non-host hospital.

- For urban single or MSA dominant hospitals, we would allow the HwH to admit from the host up to the host's percentage of total Medicare discharges in the MSA. We would apply a floor of 25 percent and a ceiling of 51 percent to this variation.

Transition Period

We have established a 4-year phase-in of this policy for existing LTCH HwHs and also for LTCHs-under-formation that satisfy the following two-prong requirement:

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

  - Before October 1, 2005 designation as a LTCH.

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

Payments under this policy will be based on a reconciliation at cost report submission in order to determine the total number of discharges from the LTCH in a cost reporting period. Further instructions describing a procedure for reconfiguration of claims beyond the hospital's specific threshold will be forthcoming.

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

- If the percentage of LTCH HwH discharges originating from the host does not exceed the percentage for such patients established during the provider's 2004 cost report period, payments will be made under the LTCH PPS.

- If the percentage of such discharges exceeds the number of such discharges from the host hospital in its 2004 cost reporting period, for those discharges in excess of that percentage, Medicare will pay under the basic payment formula specified above.

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

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

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

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

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

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

Year 4 – (cost reporting periods beginning on or after October 1, 2007 (full phase in))

- LTCH HwHs will be paid under the otherwise unadjusted LTCH PPS for the percentage of discharges originating from their host hospital that do not exceed the 25 percent or the applicable percentage described for "specific circumstances above."

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

C. Provider Education:

A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3459.1	Medicare Contractors shall install IPPS and LTCH Pricers with the implementation of the October quarterly release.					X				
3459.2	Medicare Contractors shall install the MCE and Grouper software with the implementation of the October quarterly release.					X				
3459.3	FIs shall update the provider specific files for <u>every</u> IPPS hospital according to section D under Policy.	X								
3459.3.1	FIs shall update the provider specific files for LTCH PPS hospitals with a minimum of the Fiscal Year Begin Date and other fields as needed.	X								
3459.4	CWF shall update edit 7272 per CR 3285 with the new postacute care DRGs listed in this CR.								X	
3459.5	FIs shall determine the percentage of discharges from an LTCH HwH during FY 04 that originated from the host hospital.	X								
3459.5.1	FIs shall annually evaluate HwHs compliance with requirements of revised 412.22(e) and compute payment adjustment at cost report settlement.	X								

II. 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, Grouper, and PSFs

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING
V.

Effective Date*: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** For questions on any of the policies outlined here: Postacute Care DRGs and New Tech Add-on-Meredith Walz at mwalz@cms.hhs.gov, CBSAs / Wage Index / questions about appropriate hospital listing for wage index-Margot Blige Holloway at mbligeholloway @cms.hhs.gov, LTCH-Judy Richter at jrichter@cms.hhs.gov, or Other, contact the Division of Acute Care at (410) 786-4548. For claims processing, entering data in the provider specific file, or Pricer questions, contact Sarah Shirey at (410) 786-0187, email sshirey@cms.hhs.gov or Stuart Barranco at (410) 786-6152. **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

Attachments

To download the Filename R309CP2.zip associated with this instruction, click here.

To download the Filename R309CP3.zip associated with this instruction, click here.