Medlearn Matters
Information for Medicare Providers

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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

Provider Types Affected

Hospitals (IPPS and LTCH).

Provider Action Needed

This instruction outlines important policies in the IPPS Final Rule. These include New Tech Add-ons, Postacute Care Diagnosis Related Groups (DRGs), Core-Based Statistical Areas (CBSAs), Hospital Quality Initiative, Low Volume Hospitals, LTCH hospitals within hospitals (HwH), and other changes related to capital payments.

Background

This instruction 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 instruction also addresses new Grouper and DRG changes that are effective October 1, 2004 for hospitals paid under the LTCH Prospective Payment System (PPS) as well as information on the HwH provision. LTCH PPS rate changes occurred on July 1, 2004. For other LTCH policy changes, please also refer to:

- Transmittal 208, Change Request (CR) 3335, published on June 18, 2004, Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update, at: http://www.cms.hhs.gov/manuals/pm_trans/R208CP.pdf
- Transmittal 240, CR 3279, published on July 23, 2004, Expansion of the Existing Interrupted Stay Policy Under Long Term Care Hospital (LTCH) Prospective Payment System, at http://www.cms.hhs.gov/manuals/pm_trans/R240CP.pdf
- Transmittal 267, CR 3391, published on July 30, 2004, Crossover Patients in New Long Term Care Hospitals, at http://www.cms.hhs.gov/manuals/pm_trans/R267CP.pdf

Key changes are as follows:

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Changes

ICD-9-CM coding changes are effective October 1, 2004, and the new ICD-9-CM codes are listed, along with their 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 The ICD-9-CM codes that have been replaced by expanded codes or other codes or that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 11, 2004 Federal Register can be found at the following CMS web site:

http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf

Furnished Software Changes

The following software programs were issued to Medicare claims processing system maintainers for FY 2005:

Grouper 22.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (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 hospital discharges and outpatient services effective October 1, 2004.

IPPS Pricer 05.0
IPPS Pricer 05.0 is for discharges occurring on or after October 1, 2004.

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	1554.79	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

Please be advised that the numbers in the above two tables do not match the August 11, 2004 Federal Register, however these are the most current numbers.

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. These tables can be found at the following CMS web site:

http://www.cms.hhs.gov/providers/hipps/ippswage.asp

The August 11, 2004 Federal Register can be found at:

http://www.cms.hhs.gov/providerupdate/regs/cms1428f.pdf

2. Postacute Care Transfer Policy

On October 1, 1998, CMS established a postacute care transfer policy that paid as transfers all cases assigned to one of 10 DRGs if the patient is discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a LTCH, 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, CMS is adding two more DRGs to this list (541 and 542) and 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, 1) the OP-1 Implant, 2) CRT-D and 3) Kinetra®, in addition to InFUSE™, which was effective October 1, 2003. Xigris is no longer included.

The maximum add-on payment for InFUSE™ (ICD-9-CM procedures of 84.51 and 84.52 must both be present AND codes 81.05, 81.08, 81.35, and 81.38 MUST NOT be present) is $1,955.00. The maximum add-on payment for OP-1 (ICD-9_CM code of 84.52 MUST be present and at least one of 81.05, 81.08, 81.35, or 81.38 must also be present) is also $1,955.00. For both of these add-ons, the DRG must also be 497 or 498. The maximum add-on payment for CRT-D (ICD-9-CM code of 00.51 or 00.54 must be present) is $16,262.50 and the maximum for Kinetra® (ICD-9-CM codes 02.93 AND 86.95 must be present) 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.

Low Volume Hospitals

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 miles from another hospital. The discharges are determined from the latest cost report. The final rule identifies the process for determining which hospitals are low volume on page 49101 and 49244. Please contact your FI if you think you are a "low volume" hospital.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at the following web site: http://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'. The actual CR contains a list of the providers (by provider number) that are not receiving the quality initiative bonus.

Core-Based Statistical Area (CBSA)

Effective October 1, 2004, inpatient acute hospitals are no longer classified into a Metropolitan Statistical Area (MSA). A CBSA is now used. The CR includes two attachments. These attachments will assist your FI in determining the correct CBSA.

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 Based on the best available data, CMS has identified the following providers:

Medicare Provider Identification Numbers		
180049	190044	190144
190191	330047	340085
370016	370149	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, CMS 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 Medicare Geographic Classification Review Board (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, CMS 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), CMS has 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, CMS 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

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). 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 for the Hospital Inpatient PPS will be used for the LTCH PPS.

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.

LTCH Hospital Within Hospital (HwH) Provision

Effective for discharges from LTCHs 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), CMS has 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)
- 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 pay 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, CMS would allow the HwH to admit from the host up to the host's percentage of total Medicare discharges in the MSA. CMS would apply a floor of 25 percent and a ceiling of 51 percent to this variation.

Transition Period

CMS has 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 reconciliation at cost report submission in order to determine the total number of discharges from the LTCH in a cost reporting period.

- 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 the provider's 2004 cost reporting 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 report 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 of 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.

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

For complete details, please see the official instruction issued to your fiscal intermediary regarding this change at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3459 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your FI at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp