CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2291	**Date: August 26, 2011**
	Change Request 7508

SUBJECT: Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Critical Access Hospital (CAH) Changes

I. SUMMARY OF CHANGES: This recurring CR provides the FY 2012 update to the IPPS and LTCH PPS. Internet Only Manual updates are incorporated within this Recurring Notification. In addition this CR addresses the FY 2012 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and ICD-9-CM coding.

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: October 3, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/50.2.3/Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment
R	4/250.5/Medicare Payment for Ambulance Services Furnished by Certain CAHs

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2291	Date: August 26, 2011	Change Request: 7508

SUBJECT: Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Critical Access Hospital (CAH) Changes

Effective Date: October 1, 2011

Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background: This Change Request (CR) outlines changes to the Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Prospective Payment System (PPS) for Long Term Care Hospitals (LTCHs) for FY 2012 as well as changes to payment for critical access hospital (CAH) ambulance services. The policy changes for FY 2012 were displayed in the Federal Register on August 1, 2011, with an anticipated publication date of August 18, 2011. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted.

This CR also addresses the FY 2012 update to the Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding.

B. Policy:

ICD-9-CM Changes

The ICD-9-CM coding changes are effective October 1, 2011. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 1, 2011, Federal Register. The ICD-9-CM codes that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f.

The Grouper Contractor, 3M-HIS, introduced a new MS-DRG Grouper, Version 29.0, software package effective for discharges on or after October 1, 2011. The GROUPER 29.0 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). The Medicare Code Editor (MCE) Version 28.0 which is also developed by 3M Health Information Systems (3M-HIS), uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2011.

GROUPER 29.0 (for discharges occurring on or after October 1, 2011) – The Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors should have received the GROUPER documentation on or about August 1, 2011.

MCE 28.0 (for discharges occurring on or after October 1, 2011) – The MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation on or about August 1, 2011.

IPPS FY 2012 Update

The FY 2012 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2011. It includes all pricing files for FY 2006 through FY 2012 to process bills with discharge dates on or after October 1, 2005.

FY 2012 IPPS Rates

Standardized Amount Update Factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	$22,385
Federal Capital Rate	$421.42
Puerto Rico Capital Rate	$203.86
Outlier Offset-Operating National	0.94899
Outlier Offset-Operating Puerto Rico	0.953549
IME Formula (no change for FY12)	$1.35 \times [(1 + \text{resident to bed ratio})^{.405} - 1]$
MDH/SCH Budget Neutrality Factor	0.997903
MDH/SCH Documentation and Coding Adjustment Factor	0.9528
MDH/SCH Adjustment for Restoration of Rural Floor Budget Neutrality	1.009

Operating

Rates with Full Market Basket and Wage Index > 1	
National Labor Share	$3,584.30
National Non Labor Share	$1,625.44
PR National Labor Share	$3,584.30
PR National Non Labor Share	$1,625.44
Puerto Rico Specific Labor Share	$1,553.29
Puerto Rico Specific Non Labor Share	$947.98
Rates with Full Market Basket and Wage Index < or = 1	
National Labor Share	$3,230.04
National Non Labor Share	$1,979.70
PR National Labor Share	$3,230.04
PR National Non Labor Share	$1,979.70
Puerto Rico Specific Labor Share	$1,550.79
Puerto Rico Specific Non Labor Share	$950.48
Rates with Reduced Market Basket and Wage Index > 1	
National Labor Share	$3,513.95
National Non Labor Share	$1,593.54
PR National Labor Share	$3,584.30
PR National Non Labor Share	$1,625.44

Puerto Rico Specific Labor Share	$1,553.29
Puerto Rico Specific Non Labor Share	$947.98
Rates with Reduced Market Basket and Wage Index < or = 1	
National and PR National Labor Share	$3,166.64
National and PR National Non Labor Share	$1,940.85
PR National Labor Share	$3,230.04
PR National Non Labor Share	$1,979.70
Puerto Rico Specific Labor Share	$1,550.79
Puerto Rico Specific Non Labor Share	$950.48

Post-acute Transfer and Special Payment Policy

The following MS-DRGs will be listed as qualifying for post-acute transfer policy status as of FY 2012:

MS DRG 023 (Craniotomy with Major Device Implant or Acute Complex CNS PDX with MCC);
MS-DRG 024 (Craniotomy with Major Device Implant or Acute Complex CNS PDX without MCC);
MS-DRG 570 (Skin Debridement with MCC);
MS-DRG 571 (Skin Debridement with CC);
MS-DRG 572 (Skin Debridement without CC/MCC)

The following MS-DRGs will no longer be listed as qualifying for post-acute transfer policy status as of FY 2012:

MS-DRG 228 (Other Cardiothoracic Procedures with MCC), 229 (Other Cardiothoracic Procedures with CC);
MS-DRG 230 (Other Cardiothoracic Procedures without CC/MCC)

The following MS-DRGs will be listed as qualifying for special payment policy status as of FY 2012:

MS-DRG 216 (Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC);
MS-DRG 217 (Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC);
MS-DRG 218 (Cardiac Valve & Other Major Cardiothoracic Procedure without CC/MCC)

See Table 5 of the IPPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at the following link.

http://www.cms.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250520&intNumPerPage=10

New Technology Add-On Payments

The following items are eligible for new-technology add-on payments in FY 2012:

Continue payments for the AutoLITT- Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26 and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9

(ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount will be paid that is equal to the lesser of 50 percent of the costs of the new medical service/technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

National Rural Floor Budget Neutrality Adjustment Factors

The wage table loaded for the FY 2012 Pricer contains wage index values ALREADY ADJUSTED BY the national rural floor budget neutrality factor of 0.991007. To confirm the wage index Pricer uses in calculating payments with the wage index printed in the Federal Register, take the wage index from Pricer and compare it to the wage index value shown in Table 4A, 4B or 4C as appropriate.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, but you must update all applicable fields for IPPS hospitals effective October 1, 2011, or effective with cost reporting periods that begin on or after October 1, 2011, or upon receipt of an as-filed (tentatively) settled cost report. Pricer requires a PSF record with a 10/1 effective date.

Note: Tables 8a and 8b of section VI of the addendum to the IPPS final rule and made available on the Internet contain the FY 2012 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.152 and the capital ceiling is 0.159.

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2012. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS/LTCH PPS final rule.

Expiration of Section 508 Reclassifications

Section 508 of the 2003 Medicare Modernization Act and as extended by both the Affordable Care Act (ACA) and the Medicare and Medicaid Extenders Act of 2010 (MMEA) will no longer be in effect beginning October 1, 2011. The PSFs shall be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

Section 505 Hospital (Out-Commuting Adjustment)

Attachment A - Section 505 shows the IPPS providers that will be receiving a "special" wage index for FY 2012 (i.e., receive an out-commuting adjustment under section 505 of the MMA). For any provider with a Special Wage Index from FY 2011, FIs and A/B MACs shall remove that special wage index by entering zeros in the field unless they receive a new special wage index as listed in this attachment.

Hospitals Waiving Lugar Redesignation for the Out-Migration Adjustment

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. Below is the list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2012:

Medicare CCN	Provider Name
010164	COOSA VALLEY MEDICAL CENTER
360096	EAST LIVERPOOL CITY HOSPITAL
390150	SOUTHWEST REGIONAL MEDICAL CENTER
390201	POCONO MEDICAL CENTER

Hospital-Specific (HSP) Rate Update for Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs)

For FY 2012, the hospital-specific (HSP) rates for SCHs and MDHs in the PSF will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2012 is 1.9 percent (or -0.10 percent for hospitals that do not submit quality data) and the budget neutrality factor for DRG reclassification and recalibration is 0.997903. For FY 2012, a cumulative documentation and coding adjustment factor of 0.9528 will be applied to the HSP rates (this factor includes the permanent 2.9 percent reduction implemented in FY 2011 and the additional permanent 2.0 percent reduction implemented beginning in FY 2012). Beginning in FY 2012, a permanent adjustment for restoring rural floor budget neutrality of 1.009 will also be applied to the HSP rates.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2012

Sections 3125 and 10314 of the Affordable Care Act amended the low-volume hospital adjustment in section 1886(d)(12) of the Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at §412.101 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275).

In the FY 2012 IPPS/LTCH PPS final rule, CMS established that for FY 2012 the low-volume payment adjustment will be determined using FY 2012 Medicare discharge data from the March 2011 update of the MedPAR files. In Table 14 of the Addendum to that final rule, CMS provided a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2011 update of the FY 2010 MedPAR files. However, this list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criterion, that is, to qualify for the low-volume adjustment, the hospital also must be located more than 15 road miles from any other IPPS hospital. **In order to receive the applicable low-volume percentage add-on payment for FY 2012, a hospital must meet both the discharge and mileage criteria.**

CMS established a procedure for a hospital to request low-volume hospital status for FY 2012 in the FY 2012 IPPS/LTCH PPS final rule, which is similar to the procedure established for the FY 2011 low-volume payment adjustment ((Transmittal 2060, Change Request 7134; October 1, 2010). For FY 2012, a hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by September 1, 2011, so that the applicable low-volume percentage add-on can be applied to payments for its discharges occurring on or after October 1, 2011. A hospital that qualified for the low-volume payment adjustment in FY 2011 may continue to receive a low-volume payment adjustment in

FY 2012, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2010 MedPAR data (shown in Table 14 of the Addendum to that final rule (available on the Internet as noted below) and the distance criterion. **However, the hospital must verify in writing to its FI or MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than September 30, 2011**. For requests for low-volume hospital status for FY 2012 received after September 1, 2011, if the hospital meets the criteria to qualify as a low-volume hospital, the FI or MAC will apply the applicable low-volume payment adjustment in determining payments to the hospital's FY 2012 discharges prospectively within 30 days of the date of the FI's or MAC's low-volume status determination.

FIs/MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2011 update of the FY 2010 MedPAR files as shown in Table 14 of the Addendum to the FY 2012 IPPS/LTCH PPS final rule and available on the Internet at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp (click on the link on the left side of the screen titled, "FY 2012 IPPS Final Rule Home Page"). (We note that in order to facilitate administrative implementation, the only source that CMS and the FIs/MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2012 is the data from the March 2011 update of the FY 2010 MedPAR file.)

The FI/MAC is to notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of any changes or additions to IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges occurring in FY 2012 by November 7, 2011. The notification may be sent via e-mail to Michele.Hudson@cms.hhs.gov and Maria.Navarro@cms.hhs.gov, and should include the hospital's name, provider number, address (street, city, state and zip code), the number of Medicare discharges, the distance to the nearest IPPS hospital (as well as that hospital's address: street, city, state and zip code) by which the hospital qualified for low-volume status, and the effective date of the low-volume hospital determination. For low-volume hospital requests received after September 1, 2011, FI/MACs shall notify CMS Central Office as above within 15 days of the determination.

In order to implement this policy for FY 2012, the Pricer will include a table containing the provider number and discharge count determined from the March 2011 update of the FY 2010 MedPAR file. The discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. The table in Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).

The existing low-volume indicator field on the Provider Specific File (position 74 on the PSF – temporary relief indicator) must be updated by the FI/MAC to hold a value of 'Y' if the provider qualifies for a low-volume payment adjustment for discharges occurring during FY 2012, by meeting **both the discharge and mileage criteria** at§ 412.101(b)(2)(ii). If a hospital qualified for the low-volume payment adjustment in FY 2011 but no longer meets either the discharge or mileage criteria, and therefore. is no longer eligible to receive a low-volume payment adjustment in FY 2012, the FI/MAC must update the low-volume indicator field on the Provider specific file (position 74 on the PSF – temporary relief indicator) to hold a value of 'blank'

The applicable low-volume percentage add-on payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs and MDHs, the applicable low-volume percentage add-on 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 FIs and A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) in the Provider Specific File for each hospital that meets the criteria for higher payments per MMA Quality standards. Leave blank if they do not meet the criteria. The hospitals that will receive the quality initiative bonus are listed at the following Web site: **www.qualitynet.org.** This Web site is expected to be updated in September 2011. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals not receiving the 2.0% RHQDAPU annual payment update for FY 2012 will be available in September.

For new hospitals, FIs and A/B MACs shall enter a '1' in the PSF and provide information to the Quality Improvement Organization (QIO) as soon as possible so that the QIO can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

The FIs and A/B MACs shall provide this information monthly to the QIO in the State in which the hospital has opened. It shall include the following:

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

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

42 CFR 412.64(b)(II)(D)(3) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the Federal payment amount for the urban area to which they are redesignated. To ensure these "Lugar hospitals" are paid correctly under the capital PPS, FIs and A/B MACs shall enter the urban Core Based Statistical Area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF, except for hospitals that waive Lugar redesignation for the out-migration adjustment (as discussed previously in this instruction). (Note: this may be different from the urban CBSA in the wage index CBSA field on the PSF for "Lugar hospitals" that are reclassified for wage index purposes.)

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

Hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)). The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the standardized amount CBSA field on the PSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the capital PPS. Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under §412.103 is determined from the applicable Statewide rural wage index.

Frontier Wage Index RFBN

Section 10324(a)(1) of ACA amended section 1886(d)(3)(E) of the Act by adding a provision under new subsection (iii) to establish an adjustment to create a wage index floor of 1.00 for all hospitals located in States determined to be "frontier States," beginning in FY 2012.

For the final FY 2012 IPPS wage indices, we identified the following frontier States that will receive the floor adjustment for FY 2012: Montana, Nevada, North Dakota, South Dakota, and Wyoming. These frontier States also are identified by a footnote in Table 4D-2 of the Addendum to the final rule. Note: The above is informational. Pricer will calculate all applicable frontier wage indices.

Section 1109

Section 1109 of Pub. L. 111-152 provides for additional payments for FYs 2011 and 2012 to "qualifying hospitals." Section 1109(d) defines a "qualifying hospital" as a "subsection (d) hospital . . . that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B . . . per enrollee within the lowest quartile of such counties in the United States." In the FY 2012 IPPS final rule, we posted tables with a list of qualifying hospitals, their payment weighting factors and eligible counties for FY 2011 and FY 2012. Our payment distribution process uses a single Medicare contractor that will directly pay all of the qualifying hospitals annually for FY 2011 and for FY 2012. We distributed $150 million for FY 2011 in July 2011 and plan on distributing the remaining $250 million for FY 2012 sometime after November 1, 2011 to qualifying hospitals. Because these one-time annual payments would be made through a special process outside of the scope of normal payments by their Medicare contractor, the hospitals' Medicare contractor does not need to track the payment amounts made to the hospitals under this provision.

LTCH PPS FY 2012 Update

FY 2011 LTCH PPS Rates

Federal Rate	$40,222.05
High Cost Outlier Fixed-Loss Amount	$17,931
Labor Share	70.199%
Non-Labor Share	29.801%

MS-LTC-DRG Update

The LTCH PPS Pricer has been updated with the Version 29.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2011, and on or before September 30, 2012.

Provider Specific File (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2011, or effective with cost reporting periods that begin on or after October 1, 2011, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8C of section VI of the addendum to the PPS final rule contain the FY 2012 Statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost

outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific total CCR from the latest settled or tentatively settled cost report. The LTCH total CCR ceiling for FY 2012 is 1.215.

Cost of Living Adjustment (COLA) Update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2012. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS/LTCH PPS final rule.

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 2012 The CBSAs definitions and codes that will continue to be effective October 1, 2011 can be found in Table 12A to the Addendum of the FY 2012 IPPS/LTCH PPS final rule, which is available on our website.

Inclusion of Medicare Advantage (MA) Days in the Average Length of Stay Calculation

The average length of stay (ALOS) calculation at 42 CFR 412.23(e)(3) specifies that all data on all Medicare inpatient days, including Medicare Advantage (MA) inpatient days, shall be included in the average length of stay calculation. When evaluating whether an LTCH meets the average ALOS requirement at §412.23(e)(3), based upon a policy clarification included in the FY 2012 IPPS/LTCH final rule, no LTCH should lose its exclusion from the IPPS (i.e., its status as an LTCH) because of the inclusion of MA inpatient days in the calculation of its ALOS until LTCH cost reporting periods beginning on or after January 1, 2012.

CMS requires on-going monitoring of LTCH compliance with the ALOS requirement at §412.23(e)(3) (see section 150.4 of Pub. 100-04, Chapter 3 of the Internet Only Manual).

Additional LTCH Policy Changes for FY 2012

In the FY 2012 IPPS/LTCH PPS final rule, the moratorium on the increase in number of beds has been extended to also apply to LTCHs and LTCH satellites that were established under one of the exceptions to the moratorium provided in section 114(d) of the MMSEA. Specifically, the number of beds in those LTCHs and LTCH satellites must not be beyond the number certified by Medicare on October 1, 2011.

Changes to Payment for CAH Ambulance Services

Effective with dates of service on or after October 1, 2011, in order for a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH. Prior to October 1, 2011, the regulations required that there be no other provider or supplier of ambulance services within a 35-mile drive of the CAH or the entity.

Also effective with dates of service on or after October 1, 2011, if there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH but there is a CAH-owned and operated entity located more than a 35-mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services, if it is the closest provider or supplier of ambulance services to the CAH.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7508.1	FISS shall install and pay claims with the FY 2012 IPPS Pricer for discharges on or after October 1, 2011**.**						X				
7508.2	FISS shall install and pay claims with the FY 2012 LTCH Pricer for discharges on or after October 1, 2011.						X				
7508.3	FISS shall install and edit claims with the MCE version 28.0 and GROUPER version 29.0 software with the implementation of the FY 2012 October quarterly release.						X				
7508.4	FISS shall establish yearly recurring hours to allow for updates to the list of ICD-9-CM diagnosis codes that are exempt from reporting Present on Admission (POA).						X				
7508.5	CWF shall update edit 7272 with the post-acute care (PAC) MS-DRGs listed in Table 5 of the IPPS Final Rule (link on page 2 of this CR) effective for discharges on or after 10/01/2011 (includes special pay).									X	
7508.6	Contractors shall inform the QIO of any new hospital that has opened for hospital quality purposes.	X		X							
7508.7	Contractors shall update relevant portions of the PSF in accordance with this CR.	X		X							
7508.7.1	Contractors shall update the PSF for CBSA and special wage index changes per the policy sections of this CR.	X		X							
7508.7.2	Contractors shall notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro, of the IPPS hospitals that qualify as a low-volume hospital and the effective date of the determination for discharges occurring in FY 2012 by November 7, 2011. Contractors shall also notify CMS Central Office – Baltimore, CM/HAPG/DAC, Michele Hudson and Maria Navarro of IPPS hospitals qualified as low-volume hospitals after September 1, 2010, within 15 days of the determination.	X		X							
7508.8	Contractors shall be aware of the manual updates included within this CR.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7508.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirement:

X-Ref Requirement Number	Recommendations or other supporting information:
7508.4	There are no changes to the POA Exempt list for FY2012.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Cami DiGiacomo at cami.digiacomo@cms.hhs.gov or 410-786-5888
Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 410-786-0187

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: ***For Medicare Administrative Contractors (MACs),*** **include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment A - Section 505

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev.2291, Issued: 08-26-11, Effective: 10-01-11, Implementation: 10-03-11)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice *beyond the end of a calendar month*, providers *must* submit a bill *for each calendar month*. (See §50.2.*1* for frequency of billing for inpatient services.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

> Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has been suspended for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above. FIs shall perform editing to ensure hospice claims are processed in sequence after any necessary medical review of the claims has been completed.

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of "clean" claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not "clean" claims.

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev*2291, Issued: 08-26-11, Effective: 10-01-11, Implementation: 10-03-11*).

Medically necessary ambulance services furnished for dates of service on or after December 21, 2000 and prior to January 1, 2004, by a CAH or by an entity that is owned and operated by the CAH are paid based on 100 percent of the reasonable cost*s* if the 35 mile rule for *reasonable* cost-based payment is met.

For dates of service on or after January 1, 2004, medically necessary ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH are paid based on 101 percent of the reasonable cost*s* if the 35 mile rule for *reasonable* cost-based payment is met.

*For dates of service on or after December 21, 2000 and prior to October 1, 2011, i*n order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH or the entity.

For dates of service on or after October 1, 2011, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH. Additionally, if there is no provider or supplier of ambulance services located within a 35 mile drive of the CAH but there is an entity owned and operated by the CAH located more than a 35 mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH.

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

Those CAHs *and CAH-owned and operated entities* that meet the 35 mile rule for *reasonable* cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

When the 35 mile rule for *reasonable* cost-based payment is not met, the CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the CAH, is paid based on the ambulance fee schedule.

Provider	FY 2012 WI
010008	0.7642
010010	0.7603
010012	0.7454
010015	0.7332
010025	0.7666
010029	0.8626
010032	0.7586
010045	0.7652
010047	0.7543
010052	0.7522
010061	0.7852
010091	0.7332
010109	0.7868
010110	0.7727
010125	0.7702
010128	0.7332
010129	0.7430
010138	0.7366
010150	0.7543
010164	0.7465
030067	0.9058
040019	0.7661
040047	0.7445
040067	0.7454
040081	0.7806
050007	1.5659
050069	1.1981
050070	1.5659
050113	1.5659
050133	1.2181
050168	1.1981
050224	1.1981
050226	1.1981
050230	1.1981
050264	1.5553
050289	1.5659
050348	1.1981
050426	1.1981
050444	1.2386
050526	1.1981
050541	1.5659
050543	1.1981
050548	1.1981
050551	1.1981
050567	1.1981
050570	1.1981

050580	1.1981
050589	1.1981
050603	1.1981
050609	1.1981
050678	1.1981
050744	1.1981
050745	1.1981
050746	1.1981
050747	1.1981
050754	1.5659
050767	1.4435
050768	1.1981
070021	1.2218
110100	0.8504
110101	0.7753
110142	0.7875
110205	0.8149
130066	0.9486
140001	0.8694
140026	0.8675
140234	0.8675
150022	0.8791
150072	0.8633
160013	0.8684
160032	0.8841
170150	0.8165
180017	0.7996
180064	0.8107
180066	0.8429
180070	0.8018
180079	0.8072
190034	0.8079
190044	0.8138
190050	0.7979
190053	0.8030
190054	0.7993
190078	0.8079
190088	0.8201
190099	0.8031
190106	0.8005
190116	0.7997
190133	0.8005
190140	0.7953
190145	0.7974
190184	0.7954
190246	0.7954
190257	0.7977

210001	0.9420
210023	1.0030
210028	0.9571
210043	1.0030
220002	1.3890
220011	1.3890
220049	1.3890
220063	1.3890
220070	1.3890
220082	1.3890
220084	1.3890
220098	1.3890
220101	1.3890
220105	1.3890
220171	1.3890
220175	1.3890
230005	0.8745
230015	0.8570
230041	0.9084
230047	0.9623
230075	1.0002
230092	0.9186
230093	0.8344
230099	0.9665
230195	0.9623
230204	0.9623
230217	1.0002
230227	0.9623
230257	0.9623
230264	0.9623
240018	1.0090
240044	0.9900
240101	0.9314
240117	0.9782
250128	0.7997
250162	0.8404
260059	0.8084
260064	0.8078
260097	0.8398
260160	0.8184
260163	0.8134
300011	1.1278
300012	1.1278
300017	1.1789
300020	1.1278
300029	1.1789
300034	1.1278

320011	0.9194
330033	0.8805
330047	0.8651
330132	0.8725
330175	0.8845
330222	0.8656
330276	0.8615
340020	0.8466
340024	0.8446
340038	0.8632
340039	0.8393
340069	0.9481
340070	0.8789
340073	0.9481
340104	0.8446
340114	0.9481
340133	0.8741
340151	0.8387
340173	0.9481
360002	0.8495
360040	0.8848
360044	0.8530
360058	0.8473
360070	0.8725
360071	0.8474
360084	0.8725
360096	0.8414
360107	0.8566
360131	0.8725
360151	0.8725
360156	0.8566
360161	0.8414
360355	0.8758
360356	0.8566
370023	0.8018
370065	0.8049
370100	0.7971
370156	0.8043
370169	0.8120
370214	0.8043
390008	0.8441
390031	0.8577
390039	0.8467
390052	0.8448
390056	0.8452
390066	0.8699
390112	0.8467

390117	0.8438
390150	0.8435
390173	0.8467
390201	0.9375
390236	0.8445
420005	0.8254
420007	0.9086
420019	0.8411
420043	0.8416
420053	0.8352
420054	0.8256
420055	0.8273
420062	0.8366
420083	0.9086
420098	0.8270
430048	1.0353
430094	1.0353
440007	0.7947
440008	0.8017
440016	0.7848
440031	0.7791
440033	0.7801
440035	0.8369
440047	0.7956
440051	0.7813
440057	0.7793
440060	0.7956
440063	0.7801
440070	0.7828
440081	0.7830
440084	0.7798
440105	0.7801
440109	0.7807
440115	0.7956
440137	0.8373
440148	0.8010
440180	0.7801
440181	0.8074
440182	0.7848
440184	0.7801
450090	0.8779
450163	0.8184
450192	0.8384
450210	0.8196
450236	0.8494
450270	0.8384
450451	0.8592

450460	0.8124
450497	0.8584
450539	0.8207
450565	0.8506
450573	0.8201
450597	0.8072
450641	0.8584
450698	0.8332
450755	0.8643
450813	0.8099
460001	0.9233
460013	0.9233
460023	0.9233
460043	0.9233
460052	0.9233
490002	0.7952
490038	0.7952
490084	0.8185
490105	0.7952
490110	0.8350
500019	1.0243
500024	1.1021
500139	1.1021
510012	0.7503
520009	0.9142
520035	0.9381
520044	0.9381
520045	0.9193
520048	0.9193
520057	0.9207
520059	0.9230
520088	0.9438
520096	0.9230
520102	0.9538
520160	0.9142
520198	0.9193