CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2366	**Date: December 9, 2011**
	Change Request 7666

SUBJECT: Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2012 Pricer

I. SUMMARY OF CHANGES: This Change Request (CR) corrects several IPPS Pricer problems. We are correcting a code for the New Tech add-on for Fiscal Year 2012, as well as correcting minor Diagnosis Related Group (DRG) in the current and prior years. The attached Recurring Update Notification applies to Chapter 3, Section 20.3.4.

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: January 3, 2012

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. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

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

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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2366	Date: December 9, 2011	Change Request: 7666

SUBJECT: Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2012 Pricer

EFFECTIVE DATE: **October 1, 2011**

IMPLEMENTATION DATE: January 3, 2012

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) was recently made aware of several IPPS Pricer problems that will be corrected with this Change Request (CR).

First, ICD-CM-9 diagnosis code 191.5 was omitted from the FY2012 IPPS Pricer list of diagnosis codes valid for the new technology add-on payment for AutoLITT™.

Second, Medical Severity Diagnosis Related Group (MS-DRG) code 009 was inadvertently included in the FY2010 IPPS Pricer table of invalid MS-DRG codes. This CR corrects the FY 2010 Pricer. This CR is also correcting other minor changes to the table of invalid MS-DRG codes in the FY 2010, FY 2011, and FY 2012 Pricers.

Finally, a problem was discovered with the revised FY 2003 and FY 2004 IPPS Pricers installed into the lump sum utility as instructed by CR7244.

This CR instructs Fiscal Intermediary Shared System (FISS) to install these Pricers into production with the January release.

B. Policy: 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 4 (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.

In addition to removing MS-DRG code 009 from the table of invalid MS-DRG codes in the FY2010 IPPS Pricer, we are adding MS-DRG codes 014, 015, 888, 889, and 890 to the table.

We are also adding MS-DRG codes 888, 889, and 890 to the table of invalid MS-DRG codes in the FY2011 IPPS Pricer.

In the FY2012 IPPS Pricer, we are adding MS-DRG codes 015, 888, 889 and 890, and removing MS-DRG codes 016, 017, 570, 571 and 572 from the table of invalid MS-DRG codes.

As a result of a U.S. District Court decision, CMS was ordered to apply a revised labor-related share (LRS) percentage to IPPS claims with discharges during FY 2003 and FY 2004 for specified hospitals. To abide by the court order and provide a lump-sum payment to each of the impacted hospitals, contractors were to run applicable claims through the “lump-sum payment utility” which included the revised FY 2003 and FY 2004 IPPS Pricer with the correct LRS percentage for applicable

hospitals as instructed in CR 7244. CMS has updated the FY 2003 and FY 2004 IPPS Pricers.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7666.1	FISS shall install and pay claims with the revised FY 2012 IPPS Pricer.						X				
7666.2	FISS shall install and pay claims with the revised FY 2011 IPPS Pricer.						X				
7666.3	FISS shall install and pay claims with the revised FY 2010 IPPS Pricer.						X				
7666.4	FISS shall install the revised FY 2004 IPPS Pricer both to the lump sum utility and to production.						X				
7666.5	FISS shall install the revised FY 2003 IPPS Pricer both to the lump sum utility and to production.						X				
7666.6	Contractors shall identify claims with ICD-9-CM diagnosis code 191.5 and ICD-9-CM procedure code 17.61 with discharge date on or after October 1, 2011 through January 1, 2012 and reprocess impacted claims.	X		X							
7666.7	Contractors shall release any pending claims or accept and process claims that received Pricer Return Code 54/Reason Code 37002 with MS-DRG 009 and a discharge date on or after October 1, 2009 through September 30, 2010 after the Pricer has been successfully installed with the January 2012 release, when brought to your attention.	X		X							
7666.8	Contractors shall release any pending claims or accept and process claims that received Pricer Return Code 54/Reason Code 37002 with MS-DRG code 016, 017, 570, 571 or 572 and a discharge date on or after October 1, 2011 after the Pricer has been successfully installed with the January 2012 release, when brought to your attention.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7666.9	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: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7666.7 and 7666.8	Hospitals that had a claim returned to provider shall resubmit their claim after January 3, 2012.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: 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.

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.