CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2028	**Date: AUGUST 13. 2010**
	Change Request 7004

Transmittal 2016, dated July 30, 2010 is rescinded and replaced by Transmittal 2028. The Effective and Implementation dates in the manual instruction have been corrected to reflect 2011 instead of 2010 as originally released. All other information remains the same.

SUBJECT: 5010 Implementation--Processing Additional International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) Diagnosis and Procedure Codes in Pricer, Grouper, and the Medicare Code Editor (MCE)

I. SUMMARY OF CHANGES: With the implementation of the 5010 837I transaction in January 2011, the number of ICD-9-CM diagnosis and procedure codes are being expanded from 9 and 6 to 25 and 25. This will require changes to the Inpatient Prospective Payment System (IPPS), Inpatient Psychiatric Facility (IPF) PPS and the Skilled Nursing Facility (SNF) Pricers and the Fiscal Intermediary Standard System (FISS) interface to these Pricers. In addition, the FISS interface to the Grouper and MCE will be changed.

EFFECTIVE DATE: *January 1, 2011
IMPLEMENTATION DATE: January 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. 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
R	3/20.2.1/Medicare Code Editor (MCE)
R	3/20.2.2/DRG GROUPER Program
R	3/160.1.1/Identifying Claims Eligible for the Add-On Payment for New Technology
R	3/190.5.3/Comorbidity Adjustments
R	3/190.10.1/General Rules
R	6/30.6.1/Input/Output Record Layout

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
The funding for this CR will fall under 5010, FMIB No. 614.

For Medicare Administrative Contractors (MACs):
The funding for this CR will fall under 5010, FMIB No. 614.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2028	Date: August 13, 2010	Change Request: 7004

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SUBJECT: 5010 Implementation--Processing Additional International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) Diagnosis and Procedure Codes in Pricer, Grouper, and the Medicare Code Editor (MCE)

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

I. GENERAL INFORMATION

A. Background: The Administrative Simplification provisions of the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require the Secretary of Health & Human Services to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically. The purpose of this change request is to direct shared systems to make the necessary base system changes related to various Pricers, Grouper, and the MCE to accommodate the changes in data content for the next version of HIPAA.

B. Policy: With the implementation of the 5010 837I, providers can now report up to 25 ICD-9-CM Diagnosis and Procedure Codes. Changes are being made to various software modules to accommodate this change and allow these additional codes to be processed.

- The Inpatient Prospective Payment System (IPPS) Pricer looks at various ICD-9-CM codes to determine the New Technology Add-on Payment.
- The Inpatient Psychiatric Facility (IPF) PPS Pricer looks at various ICD-9-CM codes to determine the comorbidity adjustment.
- The Skilled Nursing Facility PPS Pricer applies adjustments to payment based off the presence of certain ICD-9-CM codes.
- The Grouper and MCE will be able to process more ICD-9-CM codes to determine the Medicare Severity Diagnosis Related Group (MS-DRG)

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	
7004.1	The IPPS, IPF, and SNF Pricers shall expand their input and output to accept and send up to 25 ICD-9-CM diagnosis codes and 25 procedure codes.										Pricers
7004.2	The SNF Pricer shall expand its input to accept the Statement Covers From Date reported on the claim.										SNF Pricer
7004.3	The SNF Pricer shall reimburse SNF claims with a Statement Covers Thru date of 10/1/20xx off the previous year's rates when the reported Statement Covers From is prior to 10/1/20xx.										SNF Pricer
7004.3.1	The SNF Pricer shall reimburse SNF claims with a Statement Covers From and Thru date both equal to 10/1/20xx off the current FY rates.										SNF Pricer
7004.4	FISS shall expand its interface to and from the IPPS Pricer to send and receive up to 25 ICD-9-CM diagnosis codes and 25 ICD-9-CM procedure codes.						X				
7004.4.1	FISS shall expand its interface to and from the IPF Pricer to send and receive up to 25 ICD-9-CM diagnosis codes and 25 ICD-9-CM procedure codes.						X				
7004.4.2	FISS shall expand its interface to and from the SNF Pricer to send and receive up to 25 ICD-9-CM diagnosis codes and 25 procedure codes.						X				
7004.5	FISS shall expand its interface to the MCE and Grouper to send and receive up to 25 ICD-9-CM diagnosis codes and 25 procedure codes.						X				
7004.6	FISS shall expand its interface to and from the SNF Pricer to include the Statement Covers From Date reported on the claim.						X				
7004.7	Medicare systems shall note an updated SNF Pricer record layout, included with Chapter 6, Section 20.3.1, is attached to this instruction.						X				SNF Pricer
7004.8	FISS shall download and install an IPPS, IPF PPS, and a SNF Pricer for the January release. The Pricers are expected on or about November 15, 2010.						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	
7004.9	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:
7004.5	The MCE and Grouper modules have already been modified internally to process up to 25 ICD-9-CM diagnosis codes and up to 25 ICD-9-CM procedure codes.

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

V. CONTACTS

Pre-Implementation Contact(s): IPPS, IPF PPS, Grouper and MCE- Sarah.shirey-losso@cms.hhs.gov
SNF- Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

The funding for this CR will fall under 5010, FMIB # 614.

Section B: *For Medicare Administrative Contractors (MACs)*:

The funding for this CR will fall under 5010, FMIB # 614.

20.2.1 - Medicare Code Editor (MCE)

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

A. General

The MCE edits claims to detect incorrect billing data. In determining the appropriate *MS*-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a *MS*-DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the *MS*-DRG assignment:

Code Edits - Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

Coverage Edits - Examines the type of patient and procedures performed to determine if the services where covered.

Clinical Edits - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B. Implementation Requirements

The FI*/MAC* processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. Bill System/MCE Interface

The FI/*MAC* installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the bill:

- Age;
- Sex;
- Discharge status;
- Diagnosis (*25* maximum – principal diagnosis and up to *24* additional diagnoses);
- Procedures (*25* maximum); and
- Discharge date.

The MCE provides the FI/*MAC* an analysis of "errors" on the bill as described in subsection D. The FI/*MAC* develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the FI/*MAC* considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI/*MAC* returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. Invalid Fourth or Fifth Digit

The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI/*MAC*. The FI/*MAC* returns claims edited for this reason to the hospital. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

3. E-Code as Principal Diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume l (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

4. Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity MS-DRG. Hospitals may not repeat a diagnosis code. The FI/*MAC* will delete the duplicate secondary diagnosis and process the bill.

5. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.

- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.

- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The diagnoses described in the Medicare Code Editor, posted on the CMS Webpage at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10 are acceptable only for the age categories shown. If the FI/*MAC* edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI/*MAC* edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis or patient's age before returning the bill.

6. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).

- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The *MCE* contains listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

7. Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. The *MCE* contains listings of ICD-9-CM diagnoses identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

8. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

9. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign Hypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

The *MCE* contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs or the FIs may review on a post-payment basis all questionable admission cases. Where the A/B MACs or the FIs determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

10. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, Vl73 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." The A/B MAC or the FI may review claims with diagnosis V571, V5721, V5722, V573, V5789, and V579 and a secondary diagnosis. A/B MACs or FIs may choose to review as a principal diagnosis if data analysis deems it a priority.

If these codes are identified without a secondary diagnosis, the FI/*MAC* returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

11. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

12. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The FI/*MAC* will return the bill requesting that the non-covered procedure and its associated charges be removed from the covered claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the

non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

13. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The MS-DRG Grouper logic assign a patient to different MS-DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI/*MAC* requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the FI/*MAC* changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The FI/*MAC* assigns the appropriate closed biopsy code after reviewing the medical information.

14. Medicare as Secondary Payer - MSP Alert

The MCE identifies situations that may involve automobile medical, no-fault or liability insurance. The hospital must develop other insurance coverage as provided in the Medicare Secondary Payer Manuals, before billing Medicare.

15. Bilateral Procedure

There are codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The FI/*MAC* processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the FI/*MAC* may develop claims prior to payment on a provider-specific basis.

16. Invalid Age

If the hospital reports an age over l24, the FI/*MAC* requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

17. Invalid Sex

A patient's sex is sometimes necessary for appropriate *MS*-DRG determination. Usually the FI/*MAC* can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

18. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate *MS*-DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

19. Invalid Discharge Date

An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered.

20 – Limited Coverage

Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The FIs/*MACs* will handle these procedures as they had previously.

20.2.2 - DRG GROUPER Program

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

The FI/*MAC* pays for inpatient hospital services on the basis of a rate per discharge that varies according to the *MS*-DRG to which a beneficiary's stay is assigned. Each *MS*-DRG represents the average resources required to care for a case in that particular *MS*-DRG relative to the national average of resources consumed per case. The *MS*-DRG weights used to calculate payment are in the Pricer DRGX file.

The FI/*MAC* uses the GROUPER program to assign the *MS*-DRG number. GROUPER determines the *MS*-DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the FI/*MAC* or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the *MS*-DRG price. GROUPER input/output are specified below. The FI/*MAC* determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1 - Principal and up to *24* other ICD-9-CM diagnoses

2 - Principal and up to *24* additional ICD-9-CM procedures

3 - Age at last birthday at admission

4 - Sex (1=male and 2=female)

5 - Discharge destination (patient status code from the claim)

The claim sex coding is M for male and F for female while GROUPER is l for male and 2 for female. Discharge destination codes are similar to claim definitions for patient status except codes 20-29 are summarized as 20. The FI/*MAC* calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1 - Major diagnostic category

2 - *MS*-DRG number

3 - Grouper return code (a one position code indicating the action taken by the program)

4 - Procedure code used in determining the *MS*-DRG

5 - Diagnosis code used in determining the *MS*-DRG

6 - Secondary diagnosis code used in determining the *MS*-DRG, if applicable

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

Technologies eligible for add-on payments are identified based on the applicable codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Claims submitted with an ICD-9-CM code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers pass (if present) the "principal" and up to *twenty four* "other procedure" codes to PRICER. If an eligible code is present, PRICER calculates an add-on payment if appropriate.

Additionally, the National Uniform Billing Committee has approved value code 77 (FL 39-41 of the CMS-1450 or electronic equivalent) for FI use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code must be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

190.5.3 - Comorbidity Adjustments

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and not reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay or affect both treatment and the length of stay. IPFs enter the full ICD-9-CM codes for up to *twenty four* additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has 17 comorbidity categories, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-9-CM codes that are associated with each category is on the IPF PPS Web site at www.cms.hhs.gov/inpatientpsychfacilpps .

The 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	**Adjustment Factor**
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	1.13
Eating and Conduct Disorders	1.12
Infectious Disease	1.07
Drug and/or Alcohol Induced Mental Disorders	1.03

Description of Comorbidity	Adjustment Factor
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings - Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

190.10.1 - General Rules

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- *Medicare* provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must code diagnoses correctly; using ICD-9-CM codes for the principal diagnosis, and up to *twenty four* additional diagnoses, if applicable;
- The IPF must code procedures correctly using ICD-9-CM Volume III codes for one principal procedure and up to *twenty four* additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and
- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date (or effective December 3, 2007, benefits exhaust date, if present) on the claim will determine the DRG/MS-DRG assignment.

30.6.1 - Input/Output Record Layout

(Rev. 2028, Issued: 08-13-10, Effective: 01-01-11, Implementation: 01-03-11)

The SNF Pricer input/output file will be *250* bytes in length. The required data and format are shown below.

File Position	Format	Title	Description
1-4	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file.
5-9	X(5)	CBSA	*Input item:* Core-Based Statistical Area
10	X	SPEC-WI-IND	*Input item (if applicable)* :Special Wage Index Indicator Valid Values: **Y** (yes) or **N** (no)
11-16	X(6)	SPEC-WI	*Input item (if applicable):* Special Wage Index
17-21	X(5)	HIPPS-CODE	Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line
22-29	9(8)	*FROM-DATE*	*Input item: The statement covers period "from" date, copied from the claim form. Date format must be CCYYMMDD.*
30-37	9(8)	THRU-DATE	Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.
3*8*	X	SNF-FED-BLEND	Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or after 7/1/98. Medicare claims

			processing systems pull this code from field 19 of the provider specific file. **Transition Codes:** Faci1ity % Federal % **1** 75 25 (1st year) **2** 50 50 (2nd year) **3** 25 75 (3rd year) **4** 0 100 (full fed rate) **NOTE**: All facilities have been paid at the full federal rate since FY 2002.
39-45	9(05)V9(02)	SNF-FACILITY RATE	Input item: Rate based on each SNF's historical costs (from intermediary audited cost reports) including exception payments. **NOTE**: All facilities have been paid at the full federal rate since FY 2002.
46-52	X(*7*)	SNF-PRIN-DIAG-CODE	Input item: The principle diagnosis code, copied from the claim form. Must be *three to seven* positions left justified with no decimal points.
53-59	X(*7*)	SNF-OTHER-DIAG-CODE2	Input item: Additional Diagnosis Code, copied from the claim form, if present, must be *three to seven* positions left justified with no decimal points.
60-221	Defined above	Additional Diagnosis data	Input item: Up to *twenty-three* additional diagnosis codes accepted from claim. Copied from the claim form. Must be *three to seven* positions left justified with no decimal points.
222-229	9(06)V9(02)	SNF-PAYMENT RATE	Output item: Calculated per diem amount received by the SNF that includes a base payment amount adjusted for local wages and the clinical characteristics of individual patients.
230-231	9(2)	SNF-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.

			Payment return code: 00 RUG III group rate returned **Error return codes:** 20 Bad RUG code 30 Bad MSA code 40 Thru date < July 1,1998 or Invalid 50 Invalid federal blend for that Year 60 Invalid federal blend 61 Federal blend = 0 and SNF Thru date < January 1, 2000
232-250	X(*19*)	FILLER	Blank

Input records on claims must include all input items. Output records will contain all input and output items.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The SNF-PAYMENT-RATE amount for each HIPPS code will be placed in the rate field of the appropriate revenue code 0022 line. The Medicare claims processing systems will multiply the rate on each 0022 line by the number of units that correspond to each line. The system will sum all 0022 lines and place this amount in the "Provider Reimbursement" field minus any coinsurance due from the patient. For claims with dates of service on or after July 1, 2002, Pricer will compute payment only where the SNF-RTC is 00.