CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10669	**Date: March 9, 2021**
	Change Request 12062

Transmittal 10572, dated January 15, 2021, is being rescinded and replaced by Transmittal 10669, dated, March 9, 2021 to revise business requirement 12062.2, add business requirement 12062.3, and update the Background information. All other information remains the same.

SUBJECT: April 2021 Update to the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS)

I. SUMMARY OF CHANGES: This recurring change request provides a mechanism to update to the FY 2021 IPPS PPS Pricer.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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 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

Attachment - Recurring Update Notification

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I. GENERAL INFORMATION

A. Background: Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 200l, final rule (66 FR 46902), CMS established that cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the Diagnosis-Related Group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for Indirect Medical Education (IME) and Disproportionate Share Hospitals (DSH) but excluding outlier payments). PRICER calculates the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. This recurring change request provides an update to the FY 2021 IPPS PPS Pricer to allow for up to 10 National Drug Codes to be passed to the IPPS PPS Pricer for payment consideration of New Technologies and emerging medical services.

Section 3710 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act directs the Secretary to increase the weighting factor of the assigned Diagnosis-Related Group (DRG) by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 public health emergency period. CMS implemented the provisions of section 3710 of the CARES Act in Change Request (CR) 11764 (Transmittal 10058; April 24, 2020). CR 11764 established that discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes: B97.29 (Other Coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020 and on or before March 31, 2020; and U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 through the duration of the COVID-19 public health emergency period.

Included in this recurring CR is an update to the Pricer logic related to the 20% increase to the DRG weight applicable to COVID-19 discharges in Fiscal Years (FY) 2020 and 2021, implemented under Section 3710 of the CARES Act. This change allows the Part A MACs to update impacted cost reports with the correct Hospital Specific (HSP) rate payment for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs).

This update also includes a fix for the calculation of the Disproportionate Share Hospital (DSH) payment, where the payment was not applied correctly for Rural Referral Centers (RRC), including those that are also an SCH, and MDH providers with a Core-Based Statistical Area (CBSA) location that is not Rural. The DSH payment updates are applicable for claims processed between 10/08/2020 and 11/20/2020, with discharges occurring on or after 10/01/2018 through 09/30/2020.

Also included in this recurring CR is an update to correct the dollar amount displayed in the PPS Outlier Threshold. This dollar amount is used to determine the first day after the Cost Outlier threshold is reached. This change impacts the reporting of the Occurrence Code 47 date, and application of the beneficiary's Lifetime Reserve and/or Coinsurance Days. For Medicare purposes, a beneficiary must have regular, coinsurance, and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making a cost outlier payment. The PPS Outlier Threshold update applies to claims processed on or after 01/04/2021 and prior to the implementation of the updated IPPS Pricer, with discharges occurring on or after 10/01/2020 through 09/30/2021.

B. Policy: This recurring update notification applies existing policy as stated in publication 100-04, chapter 3, sections 20.2.3 and 160.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12062.1	Medicare contractors shall install and pay claims with the revised FY 2021 IPPS PPS Pricer for discharges on or after October 01, 2020, effective for claims processed on or after the implementation of this CR.					X				IPPS Pricer
12062.2	Upon successful implementation of the updated FY 2021 IPPS Pricer, Medicare contractors shall reprocess claims meeting the following criteria, no later than June 1, 2021: **For correction of the DSH payment:** • Discharge date between 10/01/2018 and 09/30/2020 (FYs 2019 and 2020 claims), • Provider is a Rural Referral Center (RRC), Medicare Dependent Hospital (MDH), MDH RRC, Sole Community Hospital (SCH) RRC, or Essential Access Community Hospital (EACH) RRC, • The Provider Specific File contained a non-rural (five digit) CBSA code in the Standard Amount Location CBSA field at the time of discharge, • The impacted claims were processed between 10/08/2020 and 11/20/2020.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	For change related to the HSP rate: • Discharge date is on or after 01/27/2020, and on or before 03/31/2020, and diagnosis code B97.29 is reported, OR the discharge date is on or after April 1, 2020 and diagnosis code U07.1 is reported. • Provider is a MDH, MDH RRC, SCH, SCH RRC, EACH, or EACH RRC, • The impacted claims were processed prior to the implementation of the updated IPPS Pricer. **Note:** For admissions occurring on or after 09/01/2020, claims reporting Condition Code ZA may be excluded from the reprocessing criteria.									
12062.3	Medicare contractors shall adjust claims to correct the Occurrence Code 47 date, and application of Lifetime Reserve and/or Coinsurance days when notified by providers that a correction is needed. The impacted claims were processed on or after 01/04/2021 and prior to the implementation of the updated IPPS Pricer, effective for discharges on or after 10/01/2020 through 09/30/2021.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12062.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized	X				

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Yvette Rivas, yvette.rivas@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0