

FINAL MEDICARE PRICER CHANGES FOR FY 2010

The Centers for Medicare and Medicaid Services (CMS) is revising the Medicare Hospital Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2010. These changes are described in the IPPS *Final Rule*, which was published in the August 27, 2009 *Federal Register* and is currently available on the CMS web site. Changes are based on continued experience with this payment system and are also in response to the comments received on the FY 2010 Proposed Rule. Other changes implement requirements from the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007, and certain provisions made by the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, and the American Recovery and Reinvestment Act of 2009. Changes to the reimbursement formulas, base rates, and factors used to determine payment for inpatient hospital services are summarized below.

UPDATES TO MEDICARE INPATIENT RATES AND PROVISIONS

1. **DOCUMENTATION AND CODING ADJUSTMENT:** The fiscal 2008 standardized payment amounts included a 1.2 percent reduction to adjust for an anticipated increase in case mix due to improved coding and documentation. Planned for fiscal 2009 and 2010 was a 1.8 percent reduction each year. On September 29, 2007, the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007, Pub. L. 110-90 was enacted. This law included a provision that changed the documentation and coding adjustment to a 0.6 percent reduction for fiscal 2008 and 0.9 percent reduction for fiscal 2009. The documentation and coding adjustments are cumulative. The 0.9 percent reduction for fiscal 2009 is in addition to the 0.6 percent reduction in fiscal 2008, yielding a total reduction of 1.5 percent. CMS will maintain this cumulative 1.5 percent adjustment in FY 2010.

CMS was to measure and corroborate the extent of the overall national average changes in case mix for FY 2008 and FY 2009. Public Law 110-90 requires CMS to make an additional adjustment to the standardized amounts that must offset the estimated increase or decrease in aggregate payments for fiscal years 2008 and 2009 (including interest) resulting from the difference between the estimated actual documentation and coding effect and the documentation and coding adjustment applied. This adjustment is in addition to making an appropriate adjustment to the standardized amounts. These recoupment or repayment adjustments must be made for discharges occurring during fiscal years 2010, 2011, and 2012.

Comprehensive data analysis reveals that the 2.5 percent estimate accurately reflected the fiscal 2008 increases in documentation and coding under the MS-DRG system. Data also supports a current estimate of the fiscal 2009 MS-DRG documentation and coding effect of 2.3 percent. The adjustment to recoup the understated coding adjustments from prior years totals 1.9 percent. The law allows CMS the discretion to decide when during the three-year period from 2010 to 2012 to apply this correction adjustment. CMS postponed this offset adjustment as the agency wants data on the magnitude of the documentation and coding effect in fiscal 2009. If the documentation and coding effect in fiscal 2009 turns out to be less than estimated, it could lessen the anticipated recoupment adjustment. The agency wants to wait until there is a

complete year of data on the fiscal 2009 documentation and coding effect before applying a recoupment adjustment for IPPS spending.

2. **INPATIENT ADJUSTED OPERATING STANDARDIZED AMOUNTS:** The methodology for updating FY 2010 operating standardized amounts is documented in the addendum to the rule.
 - **Update Factor:** For hospitals submitting quality data, the FY 2010 update factor (based on the most recent forecast of the hospital market basket increase) is 2.1%. Hospitals that do not submit quality data will receive only a 0.1% update (2.1% reduced by 2.0%). For additional information on the reporting of hospital quality data, see *Industry Insight No. 478, Medicare Quality Changes for FY 2010*.
 - **Labor-Related Share:** Under the IPPS, the labor-related share of the standardized amount is adjusted by the hospital wage index. For FY 2010, CMS will continue to apply two different labor-related shares depending on the hospital's wage index. For hospitals with a wage index greater than 1.0000 (except those located in Puerto Rico) the labor-related share is decreasing slightly, from 69.7% to 68.8%. For all hospitals with a wage index less than or equal to 1.0000, the labor-related share will continue to be 62%. For Puerto Rico hospitals, the national labor-related share will always be 62%, since the national wage index for all Puerto Rico hospitals is less than 1.0000. The labor-related share of each hospital's Puerto-Rico-specific rate is increasing to 62.1%, if the Puerto Rico index is less than 1.0000 or 62%.
 - **FY 2010 Standardized Operating Amounts:** FY 2010 standardized amounts are published in Tables 1A through 1C. Table 1A contains national standardized amounts, with either the full update (2.1%) or reduced update (0.1%) for hospitals utilizing the 68.8% labor share (wage index greater than 1.0000). Table 1B contains national standardized amounts, with full and reduced updates, for hospitals utilizing a 62% labor share. Table 1C contains Puerto Rico operating standardized amounts.
3. **CAPITAL TEACHING ADJUSTMENT:** In the 2008 final IPPS rule, CMS announced that it would phase out the capital IPPS teaching adjustment with a 50 percent reduction in fiscal 2009 and a complete elimination in fiscal 2010. The American Recovery and Reinvestment Act of 2009 (ARRA) directed CMS not to apply the 50 percent adjustment in fiscal 2009, but specified that the ARRA provision would not affect the phase-out of the capital IPPS teaching adjustment for fiscal 2010 and subsequent fiscal years. In the FY 2010 Final Rule, CMS considered public comments and to decided to allow the full capital IPPS teaching adjustment for FY 2010.
4. **MEDICARE DISPROPORTIONATE SHARE HOSPITALS:** CMS finalized three changes to the Medicare disproportionate share hospital (DSH) adjustment. The first will allow patient days associated with beds for labor and delivery (L&D) days to be included, even when the patient did not occupy a routine bed prior to occupying an L&D bed. CMS rationalizes that L&D beds are inpatient beds and the patient days spent in L&D beds are generally payable under the IPPS. This change will provide increasing DSH payments to a number of facilities.

The second change is the exclusion of all observation beds and patient days from the DSH calculation. The rationale is that a patient who is receiving observation services is considered an outpatient, not an inpatient. This is consistent with the fact that observation days are not deducted from a beneficiary's inpatient hospital benefit. The exclusion of all observation beds and patient days also applies to the available bed count used for IME payment purposes.

The third change will allow hospitals the discretion of aggregating inpatient days for the numerator of the Medicaid fraction of the disproportionate patient percentage by date of discharge, date of admission, or dates of service.

CHANGES TO AREA WAGE AND COST OF LIVING ADJUSTMENTS

1. **WAGE INDEX RECLASSIFICATIONS:** In the Acute Care Prospective Payment System, as in most other care settings, Medicare adjusts reimbursement to take into account the cost of labor in the hospital's geographical area. Geographic area is now determined based on the hospital's CBSA, or core base statistical area. Hospitals not located in a CBSA are paid based on the statewide rural wage index. However, hospitals can apply for reclassification to another geographical area, if they can prove that they draw from the same labor pool. The following hospital reclassifications are available for FY 2010:
 - **MGCRB Reclassifications:** A total of 861 hospitals are reclassified for FY 2010. This includes hospitals reclassified in FY 2008 or FY 2009 that are in the second or third year of their three-year reclassification.
 - **Section 508 Reclassifications:** Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) instituted a one-time, three-year appeal process for wage index classifications. This provision expires at the end of FY 2009. The section 508 reclassification is a non-budget neutral provision and overall payments will be reduced as a result of the expiration of this provision.
 - **Other Reclassifications:** Urban hospitals re-designated as rural under 1886(d)(8)(E) of the Social Security Act – known as Lugar hospitals – are listed in Table 9C. Rural counties re-designated as urban under Section 1886(d)(8)(B) of the Social Security Act are also listed in the Final Rule.
2. **GEOGRAPHIC RECLASSIFICATION AVERAGE HOURLY WAGE CRITERIA:** In the FY 2009 Final Rule, CMS adjusted the reclassification average hourly wage standard that is used to determine whether the average hourly wage of a hospital or county hospital group seeking reclassification is sufficiently close to the average hourly wage of the area to which the hospital or county hospital group seeks reclassification. The change in the standard is being phased-in over two years. Applications for reclassification for FY 2010 must meet the average hourly wage standards of 86 percent for urban hospitals and group reclassifications and 84 percent for rural hospitals. Applications for reclassification for FY 2011 and for subsequent fiscal years, the average hourly wage standards will be 88 percent for urban and group reclassifications and 86 percent for rural hospitals.
3. **RURAL FLOOR:** The Balanced Budget Act of 1997 (BBA) allows that the wage index for a hospital in any urban area cannot be less than the area wage index determined for the state's rural areas. Urban hospitals can be reimbursed using the statewide rural average, if that average is greater than the hospital's own wage index. Currently, 66 hospitals in 27 states take advantage of this option. Each time a hospital elects to use the rural floor, the corresponding increase in reimbursement to that hospital requires negative adjustments to reimbursement for all other hospitals in order to maintain budget neutrality.

In the FY 2009 Final Rule, CMS adopted a policy to apply state-level budget neutrality (rather than the national budget neutrality adjustment) to the rural and imputed floors. The transition from the national budget neutrality adjustment to the state-level budget neutrality adjustment is being phased in over a three-year period. In FY 2009, hospitals received a blended wage index that was 20 percent of a wage index with the state-level rural and imputed floor budget neutrality adjustment and 80 percent of a wage index with the national budget neutrality adjustment. In FY 2010, the blended wage index will reflect 50 percent of the state-level adjustment and 50 percent of the national adjustment. In FY 2011, the adjustment will be 100 percent the state-level methodology.

4. **WAGE INDEX ADJUSTMENT BASED ON COMMUTING PATTERNS OF HOSPITAL EMPLOYEES:** Section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a process for adjusting hospital wage indexes based on the commuting patterns of hospital employees. This process provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different county with a higher wage index. Outmigration adjustments are effective for three years and do not apply to hospitals that have been re-classified for purposes of the wage index. Hospitals that first received the outmigration adjustment in FY 2009 will be eligible to retain that same adjustment for FY 2010. For hospitals in newly qualified counties, adjustments to the wage index will be effective for three years, beginning with discharges occurring on or after October 1, 2009. Outmigration factors for FY 2010 are listed in Table 4J of the Final Rule.
5. **OCCUPATIONAL MIX SURVEY:** Medicare used occupational mix data collected on a revised 2007-2008 Medicare Wage Index Occupational Mix Survey, to compute the FY 2010 occupational mix adjustment. Since, the occupational mix adjustment is required by statute all hospitals subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey; unless the hospital has no associated cost report wage data that is included in the FY 2010 wage index. CMS is concerned about the increasing number of hospitals that fail to submit occupational mix data and the impact it may have on area wage indexes. For the FY 2010 Final Rule, there are seven core-based statistical areas (CBSA) for which there was no occupational mix data for any of the hospitals. Additionally, the survey response rate dropped significantly from 93.8 percent for the 2003 survey to 90.3 percent for the 2007-2008 survey. In 40 areas, the response rate was only 70 percent or lower. Since, the 2007 IPPS Final Rule, CMS has discussed applying a penalty to hospitals that fail to submit occupational mix survey data. While no penalty has yet been adopted, CMS reserves the right to apply a penalty to nonresponsive hospitals. The agency promises to address this issue in next year's IPPS Proposed Rule.
6. **COST-OF-LIVING ADJUSTMENT FACTORS:** For FY 2010, the cost-of-living adjustment (COLA) factor for hospitals in Alaska and Hawaii are revised as follows:

<u>ALASKA</u>	<u>COLA</u>
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Alaska – all other areas	1.25
<u>HAWAII</u>	<u>COLA</u>
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

DRG WEIGHT RECALIBRATION

1. **CONSTRUCTION OF WEIGHTS:** In developing the FY 2010 weights, CMS used two data sources: 1) FY 2008 MedPAR data; which includes approximately 11.3 million claims representing discharges from October 1, 2007 through September 30, 2008, from all hospitals subject to the IPPS (plus Maryland hospitals), and 2) the December 31, 2008 update of the FY 2007 Medicare cost report files. Final weights can be found in Table 5 of the Final Rule. Table 5 also contains DRG-specific mean lengths of stay (both geometric and arithmetic).

2. **COST-BASED WEIGHTS:** In FY 2007, CMS replaced its charge-based relative weight methodology with a cost-based methodology. Cost-based DRG relative weights were implemented over a three-year period, during which payment was based on a blend of charge-based and cost-based weights. In FY 2009 and subsequent years, the relative weights will be 100% cost-based.
3. **SEVERITY-BASED WEIGHTS:** A two-year transition was used to implement the MS DRG system. In FY 2008, 50% of the relative weight for each MS DRG was based on the CMS DRG relative weight that was in effect prior to the introduction of severity adjustment, and 50% was based on the MS DRG relative weight. In FY 2009 and subsequent years, the relative weights will be based entirely on the MS DRG relative weight.
4. **LOW-VOLUME DRGS:** For FY 2010, there are only eight low volume MS-DRGs (e.g., groupings with less than 10 cases) and all of these MS DRGs are for newborns or maternity. For FY 2010, CMS has computed weights for these low volume MS DRGs by adjusting the corresponding FY 2009 weights by the percentage change in the average weight of the cases in other MS DRGs. The crosswalk for these low volume MS DRGs can be found in the Final Rule.

OUTLIER PAYMENT METHODOLOGY

1. **FY 2010 OUTLIER THRESHOLDS AND MARGINAL COST FACTORS:** Medicare pays extra for cases where the cost of treatment greatly exceeds the reimbursement under the MS DRG. Claims whose costs exceed a certain threshold are eligible for this extra payment, and that threshold is the sum of the base MS DRG payment plus a fixed dollar amount. The fixed loss cost outlier threshold for FY 2010 is the prospective payment rate for the MS DRG (including indirect medical education, disproportionate share, and any add-on payments for new technology), plus \$23,140. The marginal cost factor for cost outliers remains at 80%. For patients assigned to a burn MS DRG (MS DRGs 927 through 935), the marginal cost factor continues to be 90%. These thresholds and factors are projected to result in outlier payments equal to 5.1% of total IPPS payments.
2. **COST-TO-CHARGE RATIOS:** Hospital-specific cost-to-charge ratios (CCRs) continue to be used in calculating cost outlier payments, except where the intermediary is unable to calculate a CCR or calculates an operating CCR greater than 1.179 or a capital CCR greater than 0.148. In these cases, the hospital will use a statewide urban or rural average CCR for operating costs (Table 8A) and a separate statewide CCR for capital costs (Table 8B).

OTHER REVISIONS

1. **POST-ACUTE CARE TRANSFERS:** No changes were made to the post-acute care transfer policy; which applies to a qualified discharge from one of the qualifying MS-DRGs. The patient is considered a transfer when he or she is discharged to one of the following settings: psychiatric hospital or unit, inpatient rehabilitation hospital or unit, long-term care hospital, children's hospital, cancer hospital, skilled nursing facility, or home health agency.

The list of qualifying MS-DRGs remains at 273. The transferring hospital will be paid a per diem rate for each day of the hospital stay, not to exceed the full MS-DRG payment that would have been made if the patient was discharged without being transferred. Post-acute transfers involving MS-DRGs 028–030, 040–042, 219–221, 477–482, 492–494, 500–502, and 515–517 will be paid 50 percent of the MS-DRG payment, plus the single per diem amount for the first day of the stay, and 50 percent of the per diem amount for the remaining days of the stay.

- 2. NEW MEDICAL SERVICES AND TECHNOLOGIES:** CMS has established a mechanism within the IPPS for recognizing the costs of new services and technologies. The threshold for determining whether payment for a new technology or medical service is inadequate is currently equal to the lesser of 75 percent of the standardized amount, increased to reflect the difference between cost and charges, or 75 percent of one standard deviation beyond the geometric mean standardized charge for the DRG (or the case-weighted average of all relevant DRGs) to which the new medical service or technology is assigned. The payment methodology requires that Medicare pay 50 percent for the costs of the new technology in excess of the full DRG payment. Thresholds used for evaluating FY 2010 new technology applications can be found in Table 10 of the IPPS Final Rule.

There was one item that qualified for new-technology add-on payments for FY 2009. CardioWest™ Temporary Total Artificial Heart system (TAH-t) had not been covered by Medicare, and its cost was not included in MS-DRG weights. A national coverage determination effective May 2008, that extended coverage made the TAH-t eligible for payment. The new-technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 implantation of total heart replacement system, condition code 30, and the diagnosis code reflecting clinical trial—V70.7 examination of participant in clinical trial. For fiscal 2009, an add-on payment of up to \$53,000 was available. The TAH-t is still considered new technology for the purposes of the add-on payment, and CMS is continuing new-technology add-on payments for cases involving the TAH-t in fiscal 2010 with a maximum add-on payment of \$53,000.

Spiration® IBV® Valve System by Spiration, Inc. is approved for new technology add-on payments for FY 2010 with a maximum add-on payment of \$3,437.50 per case. This device is used to place (via bronchoscopy) small, one-way valves into selected small airways in the lung in order to limit airflow into selected portions of lung tissue that have prolonged air leaks following three specific surgical procedures: lobectomy, segmentectomy, or lung volume reduction surgery. The manufacturer is currently working on a clinical trial in patients with chronic obstructive pulmonary disorder. CMS felt this device represented a new technology treatment option for patients with prolonged air leaks following the specified lung surgeries and may prevent some patients from having to undergo another invasive lung surgery to resolve the air leak. The add-on payments for this technology are limited to the treatment of patients for whom the technology is indicated under FDA approval. Spiration® IBV® Valve System is described by ICD-9-CM procedure code 33.71, endoscopic insertion or replacement of bronchial valve(s). Effective October 1, 2009, the code is modified to indicate a single lobe and 33.73 will be effective for multiple lobe insertion or replacement.

- 3. SOLE COMMUNITY HOSPITALS AND MEDICARE DEPENDENT HOSPITALS:** Sole community hospitals (SCHs) and Medicare dependent hospitals (MDHs) are eligible for extra payment under IPPS. This payment is based on the hospital cost reports. SCHs receive the higher of a hospital-specific rate based on their costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS federal rate based on the standardized amount. Through and including FY 2006, a MDH received the higher of the federal rate or the federal rate plus 50 percent of the amount by which the federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. Medicare-dependent, small rural hospital (MDH) received the higher of the federal rate or the federal rate plus 50 percent of the amount by which the federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2011 an MDH will receive the higher of the federal rate or the federal rate plus 75 percent of the amount by which the federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate.

CMS neglected to apply the budget neutrality adjustment to some of the calculation discussed in the first paragraph. As a result, beginning in FY 2007 any MDH that was paid based on its FY 2002 hospital-specific rate has been paid based on a hospital-specific rate that failed to include a

cumulative budget neutrality adjustment factor to account for DRG changes from FYs 1993 through 2002.

Consistent with the prospective nature of the rates under IPPS, CMS will apply the adjustment on a prospective basis only, effective for discharges occurring on or after October 1, 2009 (FY 2010). The agency estimates that approximately 50 MDHs will be affected by the application of the cumulative budget neutrality adjustment for DRG changes from FYs 1993 through 2002. The agency estimates that application of the cumulative budget neutrality adjustment factor will lower the hospital-specific rate to the point that the federal rate would result in higher payments.

4. **INDIRECT MEDICAL EDUCATION ADJUSTMENT:** The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) modified the formula multipliers to be used in the calculation of the indirect medical education (IME) adjustment. For FY 2008 and subsequent years, the statutorily mandated formula multiplier is 1.35. CMS estimates that the application of this multiplier for FY 2010 will result in an increase of 5.5% in IME payments for every 10% increase in the resident-to-bed ratio.
5. **GRADUATE MEDICAL EDUCATION (GME):** CMS clarified the definition of a new medical residency training program. The regulations currently specify that a new medical residency program is one that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995. The accreditation must be truly "initial," as opposed to a reaccreditation of a program that existed previously at the same or another hospital. In determining that a program is truly new, CMS will use certain "supporting factors" (such as whether the program director, teaching staff, and residents are different). CMS will also consider whether there previously was a program in the same specialty at a hospital that closed and, more generally, whether that program is part of the FTE caps of any existing hospital. CMS is also specifying that a new hospital that begins training residents for the first time after July 1 will be permitted to submit a Medicare GME affiliation agreement prior to the earlier of the end of its cost reporting period or the end of the academic year in order to participate in a Medicare GME affiliated group for the remainder of the academic year.
6. **PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS:** Section 411 of the MMA requires that payments to low volume hospitals be increased by an adjustment that cannot exceed 25%. Low volume hospitals are defined in the MMA as facilities with fewer than 800 annual discharges that are located more than 25 road miles from another acute care hospital. For FY 2010, CMS will continue providing a 25% adjustment to those few hospitals that qualify. The agency expects that two providers will receive the low-volume adjustment for FY 2010 which will increase their payments by an estimated \$82,000.
7. **EMERGENCY MEDICAL TREATMENT AND LABOR ACT:** CMS is amending the EMTALA regulations regarding the waiver of EMTALA sanctions in an emergency area during an emergency period. CMS will waive EMTALA sanctions for an inappropriate transfer and for the redirection or relocation of an individual to receive a medical screening examination at an alternate location only if the hospital does not discriminate based on the source of an individual's payment or ability to pay. The change may apply to a portion of an emergency area or period. The Final Rule states that when authorized under section 1135, a waiver of EMTALA sanctions for an inappropriate transfer applies only if the transfer is necessitated by the circumstances of the declared emergency.
8. **CRITICAL ACCESS HOSPITALS:** In accordance with MIPPA, CMS will allow a CAH to receive reasonable cost-based payment for outpatient clinical diagnostic laboratory tests furnished if the individual is not physically present in the CAH at the time the laboratory specimen is collected. The individual must be receiving services directly from the CAH and must be receiving outpatient services in the CAH on the same day the specimen is collected or the specimen must be

collected by an employee of the CAH. CMS is also finalizing a policy that would apply provider-based status rules to facilities that only furnish clinical diagnostic laboratory tests to a CAH effective October 1, 2010.

CMS is revising the regulations to be consistent with the law so that CAHs that select the optional method II of reimbursement are paid at 100 percent of reasonable costs for outpatient services and not at 101 percent.

Each year, as part of the annual update to the wage index, CMS announces changes made by OMB to Core-Based Statistical Areas. The OMB redesignated three areas from Micropolitan Statistical Areas to Metropolitan Statistical Areas. The OMB change would cause CAHs located in these areas to be redesignated as urban and lose their CAH status. CMS will give CAHs in these redesignated areas a two-year period starting in FY 2010 to reclassify from urban to rural.

- 9. IMPACT ANALYSIS OF POLICY CHANGES:** The Final Rule applies to more than 3,500 acute care hospitals. Medicare payments to acute care hospitals for inpatient services occurring in FY 2010 are projected to increase by \$1.9 billion. The rule affects all types of hospitals, with rural hospitals with under 49 beds receiving the biggest percentage increases.

FOR FURTHER INFORMATION

If you have questions regarding the Medicare pricing changes for FY 2010, please contact our Client Services department at 1-800-999-DRGS (3747). For additional information on the IPPS Final Rule, see the following *Industry Insights*:

INSIGHT NO.	TITLE
475	Final Medicare DRG Changes for FY 2010
476	Final Changes to the Medicare Code Editor (MCE) for FY 2010
478	Final Medicare Quality Changes for FY 2010
479	Final ICD-9-CM Changes for FY 2010

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