



Analysis of Final Rule for FY 2010 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year (FY) 2010 revisions to the Medicare hospital inpatient prospective payment system (IPPS) was published in the August 27, 2009 issue of the *Federal Register*. This rule became effective on October 1, 2009. This analysis covers highlights of the rule that are of particular interest to health information management (HIM) professionals. Changes that were proposed in the proposed rule but not adopted in the final rule are not addressed.

CHANGES TO MEDICARE SEVERITY DRG (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS

FY 2010 MS-DRG DOCUMENTATION AND CODING ADJUSTMENT (74FR43767)

For the FY 2010 IPPS proposed rule, the Centers for Medicare and Medicaid Services (CMS) performed a retrospective evaluation of the FY 2008 data for claims paid through December 2008. Based on this evaluation, their actuaries determined that implementation of the MS-DRG system resulted in a 2.5 percent change due to documentation and coding that did not reflect real changes in case-mix for discharges occurring during FY 2008. In the analysis of data for the proposed rule, CMS found that the within-base DRG increases were almost entirely responsible for the case mix change, supporting their conclusion that the 2.5 percent estimate was an accurate reflection of the FY 2008 effect of changes in documentation and coding under the MS-DRG system. CMS analyzed the changes in the within-base DRGs to determine which MS-DRGs had the highest contributions to the increase. The top contributors were heart failure, chronic obstructive pulmonary disease, and simple pneumonia and pleurisy.

After taking into account the results of CMS' FY 2008 analysis and the expertise of their coding staff, CMS' actuaries continue to estimate that the cumulative overall effect of documentation and coding improvements under the MS-DRG system will be 4.8 percent. However, it is estimated that these improvements will be substantially complete by the

end of FY 2009. Therefore, their estimate of the FY 2009 MS-DRG documentation and coding effect for the proposed rule was 2.3 percent. CMS' current estimate of the overall case mix growth for FY 2008 based on more recent data than the data used in the proposed rule is 2.0 percent, still less than the actuaries estimate of a 2.5 percent documentation and coding increase.

After consideration of the public comments received, CMS has determined that it would be appropriate to postpone adopting documentation and coding adjustments until a full analysis of case mix changes can be completed. While CMS has the statutory authority to make a 1.9 percent prospective adjustment entirely in FY 2010, they believe it would be prudent to wait until they have complete data on the magnitude of the documentation and coding effect in FY 2009. If the documentation and coding effect were less in FY 2009 than their current estimates, it could lessen the anticipated adjustment that they currently estimate they would have to make for FY 2008 and FY 2009 combined. In future rulemaking, they will consider applying a prospective adjustment based upon a complete analysis of FY 2008 and FY 2009 claims data over an extended time period, such as 5 years, beginning in FY 2011. During this phase-in period, they intend to address any difference between the increase in FY 2009 case mix due to changes in documentation and coding that did not reflect real changes in case mix for discharges occurring during FY 2009 and the -0.9 percent prospective documentation and coding adjustment applied in the FY 2011 rulemaking cycle.

PREVENTABLE HOSPITAL-ACQUIRED CONDITIONS (HACS), INCLUDING INFECTIONS (74FR43782)

Selected HAC Categories (74FR43783)

New ICD-9-CM codes 813.46, Torus fracture of ulna, and 813.47, Torus fracture of radius and ulna, have been added to the falls and trauma HAC category.

No HAC categories have been added or removed for FY 2010. CMS plans to undertake an evaluation of the HAC program in order to develop a better understanding of the impact of this program.

CHANGES TO SPECIFIC MS-DRG CLASSIFICATIONS (74FR43785)

Infected Hip and Knee Replacements (74FR43787)

Procedure codes 80.05, Arthrotomy for removal of prosthesis without replacement, hip, and 80.06, Arthrotomy for removal of prosthesis without replacement, knee, have been moved from MS-DRGs 480, 481, 482 (Hip and Femur Procedures Except Major Joint with MCC, with CC, without CC/MCC, respectively) and 495, 496, and 497 (Local Excision of Internal Fixation Device Except Hip and Femur with MCC, with CC, and with CC/MCC, respectively) to MS-DRGs 463, 464, and 465 (Wound Debridement and Skin Graft Except Hand, for Musculoskeletal Connective Tissue Disease with MCC, with CC, without CC/MCC, respectively). MS-DRGs 463, 464, and 465 include cases that are

treated with a debridement for infection. These cases are clinically similar to those captured by procedure codes 80.05 and 80.06 where the prosthesis is removed and a new prosthesis is not inserted because of an infection. Due to character length restrictions, the titles of these MS-DRGs have not changed.

Medicare Code Editor (MCE) Changes: Diagnoses Allowed for Males Only Edit
(74FR43789)

Through an oversight, CMS inadvertently failed to add codes 603.0, Encysted hydrocele, 603.1, Infected hydrocele, 603.8, Other specified types of hydrocele, and 603.9, Hydrocele, unspecified, to the MCE edit of diagnosis allowed for males only as part of the FY 2009 IPPS changes. So, these codes have been added to the MCE edit as part of the FY 2010 changes.

MCE Changes: Manifestation Codes as Principal Diagnosis Edit (74FR43789)

Codes 365.41, Glaucoma associated with chamber angle anomalies, 365.42, Glaucoma associated with anomalies of iris, and 365.43, Glaucoma associated with other anterior segment anomalies, have been removed from the MCE edit of manifestation codes as principal diagnosis.

MCE Changes: Invalid Diagnosis or Procedure Code (74FR43789)

Code 00.01, Therapeutic ultrasound of vessels of head and neck, was inadvertently omitted from the table of valid ICD-9-CM codes. This code has now been added to the list of valid codes.

MCE Changes: Unacceptable Principal Diagnosis (74FR43790)

For FY 2008, a series of diagnostic codes were created at category 209, Neuroendocrine tumors. An instructional note under this category stated that coders should “Code first any associated multiple endocrine neoplasia syndrome (258.01-258.03).” Medicare contractors had interpreted this note to mean that none of the codes in category 209 were acceptable principal diagnoses and had entered these codes on the MCE edit for unacceptable principal diagnosis. CMS had not intended that the codes in category 209 were only acceptable as secondary diagnoses. These codes have been removed from this MCE edit.

MCE Changes: Creation of New Edit Titled “Wrong Procedure Performed”
(74FR43790)

On January 15, 2009, CMS issued three National Coverage Decision memoranda on the coverage of erroneous surgeries on Medicare patients: Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; and Surgical or Other Invasive Procedure Performed on the Wrong Patient.

To conform to these new coverage decisions, a new edit to identify cases in which wrong surgeries occurred has been created. Claims with codes E876.5, Performance of wrong operation (procedure) on correct patient, E876.6, Performance of operation (procedure) on patient not scheduled for surgery, and E876.7, Performance of correct operation (procedure) on wrong side/body part, reported in either the principal or secondary diagnosis position will be subject to the Wrong Procedures Performed edit. These claims will be rejected.

In response to several public comments suggesting that CMS begin processing all of the reported diagnosis and procedure codes, CMS acknowledged the current CMS system limitations that allow them to process only the first nine diagnosis codes and six procedure codes reported on the hospital bills and that do not allow CMS to process codes from the external cause of injury field when making an MS-DRG assignment. In anticipation of the implementation of ICD-10-CM/PCS on October 1, 2013, CMS is undertaking extensive efforts to update its systems. These system updates include plans to begin processing up to 25 diagnosis codes and 25 procedure codes as well as the ability to process codes reported in the external cause of injury field. In the meantime, hospitals should continue to report the ICD-9-CM diagnosis and procedure codes which affect the MS-DRG assignment among the first nine diagnosis and first six procedure code fields.

Should hospitals perform any of the three wrong surgeries and submit claims on which the E code is omitted or is listed in a field that CMS does not currently process for the MS-DRG assignment (the code is not reported among the first nine diagnosis codes or the code is reported in the external cause of injury field), the case may be subject to retrospective review by the Recovery Audit Contractor and then subsequently denied. Patterns of apparent coding abuse may be referred to the Office of Inspector General for additional investigation.

MCE Changes: Procedures Allowed for Females Only Edit (74FR43792)

Codes 75.37, Amnioinfusion, and 75.38, Fetal pulse oximetry, were inadvertently omitted from the MCE edit of procedures allowed for females only. These codes have now been added to this edit.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES (74FR43808)

FY 2010 Applications for New Technology Add-On Payments (74FR43812)

Spiration® IBV® Valve System (74FR43819)

CMS has approved the Spiration® IBV® Valve System for FY 2010 new technology add-on payment. This is a device that 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 surgery while still

allowing mucus, fluids, and air to exit, thereby reducing the amount of air that enters the pleural space. The device is intended to control prolonged air leaks following three specific surgical procedures: lobectomy; segmentectomy; or lung volume reduction surgery.

Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment are identified by assignment to MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) with procedure code 33.71, Endoscopic insertion or replacement of bronchial valve(s), single lobe, or 33.73, Endoscopic insertion or replacement of bronchial valve(s), multiple lobes, in combination with one of the following procedure codes: 32.22, Lung volume reduction surgery, 32.30, Thoracoscopic segmental resection of lung, 32.39, Other and unspecified segmental resection of lung, 32.41, Thoracoscopic lobectomy of lung, or 32.49, Other lobectomy of lung.

OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS AND GME (GRADUATE MEDICAL EDUCATION) COSTS

REPORTING OF HOSPITAL QUALITY DATA FOR ANNUAL HOSPITAL PAYMENT UPDATE (74FR43860)

Hospital Quality Data Reporting under Section 5001(a) of Public Law 109-171 (74FR43861)

For the FY 2010 payment determinations and subsequent payment determinations, CMS has formally retired the AMI-6 quality measure (Beta blocker on arrival) from the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. On December 31, 2008, CMS advised hospitals that they would no longer be required to submit data for this quality measure, beginning with discharges occurring on April 1, 2009. This change was based on the evolving evidence regarding AMI (acute myocardial infarction) patient care, as well as changes in the American College of Cardiology/American Heart Association (ACC/AHA) practice guidelines for ST-segment elevation myocardial infarction and non-ST segment elevation myocardial infarction, upon which AMI-6 is based.

CMS believes that immediate retirement of quality measures should occur when the clinical evidence suggests that continued collection of the data may result in harm to patients, whereas retirement of measures for reasons other than potential patient safety concerns should occur through the rulemaking process allowing for public comment. In addition, CMS believes it is appropriate to use the rulemaking process to confirm the retirement of measures that were the subject of recent immediate retirement activity.

RHODAPU Program Quality Measures for the FY 2011 Payment Determination (74FR43868)

For the FY 2011 payment determination, CMS is retaining the 41 quality measures used for the FY 2010 payment update.

Two quality measures, PSI 04 (Death among surgical patients with treatable serious complications) and Nursing Sensitive – Failure to Rescue will be combined into a single measure for the FY 2011 payment determination.

Four measures are being added to the RHQDAPU program measure set for the FY 2011 payment determination:

- SCIP-Infection-9 (Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2)
- SCIP-Infection-10 (Perioperative Temperature Management).
- Participation in a Systematic Clinical Database Registry for Stroke Care
- Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care.

The 46 RHQDAPU program quality measures adopted for the FY 2011 payment determination can be found on page 43872 of the final rule.

Chart Validation Requirements and Methods for the FY 2011 Payment Determination (74FR43882)

CMS described a timeline with respect to CDAC (Clinical Data Abstraction Center) contractor requests for paper medical records for the purpose of validating RHQDAPU program data. This timeline is intended to provide hospitals with transparent and documented correspondence about RHQDAPU program validation paper medical record requests. Beginning with CDAC contractor requests for second calendar quarter 2009 paper medical records, the CDAC contractor will request paper copies of the randomly selected medical charts from each hospital via certified mail, and the hospital will have 45 days from the date of the request (as documented on the request letter) to submit the requested records to the CDAC contractor. If the hospital does not comply within 30 days, the CDAC contractor will send a second certified letter to the hospital, reminding the hospital that it must return paper copies of the requested medical records within 45 calendar days following the date of the initial CDAC contractor medical record request. If the hospital still does not comply, then the CDAC contractor will assign a “zero” score to each data element in each missing record.

EHR Testing of Quality Measures (74FR43893)

As CMS has stated previously, they are interested in the reporting of quality measures using EHRs, and they continue to encourage hospitals to adopt and use EHRs that conform to industry standards.

Through CMS' interagency agreement with ONC (Office of the National Coordinator for Health Information Technology) previously described, the interoperable standards for EHR-based submission of the Emergency Department (ED) Throughput, Stroke, and Venous Thromboembolism (VTE) measures are scheduled to be finalized in late 2009 and will be available for review and testing. They anticipate testing the components required for the submission of clinical quality data extracted from EHRs for these measures, and are exploring different mechanisms and formats that will aid the submission process, as well as ensure that the summary measure results extracted from the EHRs are reliable.

CMS anticipates moving forward with testing CMS' technical ability to accept data from EHRs for the ED, Stroke, and VTE measures as early as July 1, 2010. They will publish a *Federal Register* notice seeking public comments on the process they intend to follow to select HER vendors/hospitals and the methodology they plan to use for testing EHR-based data submissions. These test measures are not currently required under the RHQDAPU program. As long as that remains the case, EHR test data that is received for these measures will not be used to make RHQDAPU program payment decisions.

EHR vendors/hospitals that wish to participate in the development and testing process will be able to self-nominate by sending a letter of interest to CMS by December 31, 2009 (the address can be found on page 43893 in the final rule).

For questions concerning this summary or the FY 2010 IPPS final rule, contact Sue Bowman, AHIMA's Director of Coding Policy and Compliance, at sue.bowman@ahima.org.

Resources

The final rule regarding the fiscal year 2010 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 27, 2009 issue of the *Federal Register* located at: http://www.access.gpo.gov/su_docs/fedreg/a090827c.html.

AHIMA's letter to CMS regarding the proposed rule for FY 2010 revisions to the Medicare hospital inpatient prospective payment system can be found in the Advocacy and Public Policy Center section of the AHIMA web site: <http://www.ahima.org/dc/>.