



Overview of Final Rule for FY 2011 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year (FY) 2011 revisions to the Medicare hospital inpatient prospective payment system (IPPS) was published in the August 16, 2010 issue of the *Federal Register*. This rule becomes effective on October 1, 2010. This overview 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 2011 MS-DRG DOCUMENTATION AND CODING ADJUSTMENT (75FR50057)

CMS indicated that changes due to documentation and coding that do not reflect real changes in case mix for discharges occurring during FYs 2008 and 2009 exceeded the -0.6 and -0.9 percent prospective documentation and coding adjustment for those 2 years respectively by 1.9 percentage points in FY 2008 and 3.9 percentage points in FY 2009. In total, this change exceeded the cumulative prospective adjustments by 5.8 percentage points. Since CMS often phases in rate adjustments over more than one year in order to moderate the effect on rates in any one year, they will make an adjustment of -2.9 percent to the standardized amount in FY 2011, representing approximately half of the required aggregate adjustment.

A documentation and coding adjustment of -2.9 percent is also being applied in FY 2011 to the hospital-specific rates paid to sole community hospitals and Medicare-dependent, small rural hospitals. An adjustment of -2.6 percent is being applied to the Puerto Rico specific rate in FY 2011. CMS believes these adjustments are appropriate because all hospitals have the same financial incentives for documentation and coding improvements and the same ability to benefit from the resulting increase in aggregate payments that do not reflect real change in case mix severity of illness levels.

PREVENTABLE HOSPITAL-ACQUIRED CONDITIONS (HACS), INCLUDING INFECTIONS (75FR50080)

HAC Selection (75FR50080)

No HAC categories have been added or removed for FY 2011, nor have any changes been made to HAC policies.

POA Indicator Reporting (75FR50081)

On or after January 1, 2011, hospitals are required to begin reporting present on admission (POA) indicators using the 5010 electronic transmittal standards format. The 5010 format removes the need to report a POA indicator of "1" for codes that are exempt from POA reporting. The POA indicator of "1" is currently being used because of reporting restrictions from the use of the 4010 electronic transmittal standards format. Once hospitals begin using the 5010 format, the POA field will be left blank for codes exempt from POA reporting rather than using a POA indicator of "1." CMS plans to issue CMS instructions on this reporting change.

HAC Conditions for FY 2011 (75FR50082)

Due to the expansion of ICD-9-CM code 999.6, ABO incompatibility reaction, into five new diagnosis codes, the new codes have been designated as complications/comorbidities (CCs) for FY 2011 and will replace code 999.6 in the HAC Blood Incompatibility category.

RTI Program Evaluation Summary (75FR50085)

On September 30, 2009, a contract was awarded to Research Triangle Incorporated (RTI) to evaluate the impact of the Hospital-Acquired Condition-Present on Admission (HAC-POA) provisions on the changes in the incidence of selected conditions, effects on Medicare payments, impacts on coding accuracy, unintended consequences, and infection and event rates.

RTI analysis of hospital inpatient claims data from October 2008 through September 2009 showed that the majority of all secondary diagnoses (83.69 percent) were reported with a POA indicator of "Y," meaning the condition was POA. RTI analyzed the frequency of each reported HAC-associated secondary diagnosis and the POA indicator assigned to the claim (see chart B on page 50087 of the final rule). The most frequently-reported conditions were in the Falls and Trauma HAC category.

RTI found that, of the 264,810 discharges with a HAC-associated diagnosis as a secondary diagnosis, 14,681 (5.68 percent) included HACs that were reported with a POA indicator of "N" or "U" and were identified as a HAC discharge. Of these 14,681

discharges, 3,416 discharges ultimately resulted in MS-DRG reassignment (22.72 percent). The four HAC categories that had the most discharges resulting in MS-DRG reassignment were:

1. Falls and Trauma
2. Pulmonary Embolism and Deep Vein Thrombosis Orthopedic
3. Pressure Ulcer Stages III and IV
4. Catheter-Associated Urinary Tract Infection

CMS is not changing their approach to discounting the CC or MCC assignment for selected HACs, including their policy for not paying the higher CC/MCC reimbursement when a HAC code is reported with a POA indicator of “U.” They believe that it would be inappropriate to pay a higher amount to hospitals based on incomplete or poor documentation. CMS is committed to improving the accuracy of healthcare data. Accurate and complete documentation within the health record is important for patient management, outcome measurement, and quality improvement, as well as payment accuracy. If accurate information is not available within the health record for a hospital to report a precise POA indicator, hospitals are encouraged to seek this additional documentation from their physicians and/or other hospitals if the hospital treated a patient who was transferred.

The RTI detailed report can be accessed at: <http://www.rti.org/reports/cms>.

CHANGES TO SPECIFIC MS-DRG CLASSIFICATIONS (75FR50101)

Postsurgical Hypoinsulinemia (75FR50101)

Diagnosis code 251.3, Postsurgical hypoinsulinemia, has been added to the list of principal or secondary diagnosis codes assigned to MS-DRG 008 (Simultaneous Pancreas/Kidney Transplant). As a conforming change, code 251.3 has been added to the list of acceptable principal or secondary diagnoses in MS-DRG 010.

Bone Marrow Transplants (75FR50101)

MS-DRG 009 (Bone Marrow Transplant) has been deleted and two new MS-DRGs, MS-DRG -14 (Allogeneic Bone Marrow Transplant) and MS-DRG 015 (Autologous Bone Marrow Transplant), have been created. MS-DRG 014 includes cases reported with one of the following ICD-9-CM procedure codes: 41.02; 41.03; 41.05; 41.06; or 41.08. MS-DRG 015 includes cases reported with one of the following ICD-9-CM procedure codes: 41.00; 41.01; 41.04; 41.07; or 41.09.

Discharges/Transfers of Neonates to a Designated Cancer Center or Children’s Hospital (75FR50111)

All newborn cases assigned to MS-DRGs 790 through 795 and identified with discharge status 05 (Discharged/transferred to a designated cancer center or children’s hospital)

have been reassigned to MS-DRG 789 (Neonates, Died or Transferred to another Acute Care Facility).

Vaccinations of Newborns (75FR50111)

Code V64.05, Vaccination not carried out because of caregiver refusal, has been removed from MS-DRG 794 (Neonate with Other Significant Problems) and added to the only secondary diagnosis list for MS-DRG 795 (Normal Newborn).

Medicare Code Editor (MCE) Changes: Open Biopsy Check Edit (75FR50112)

The Open Biopsy Check edit has been deleted from the MCE. CMS believes this edit no longer serves a useful purpose.

MCE Changes: Noncovered Procedure Edit (75FR50113)

Code 251.3, Postsurgical hypoinsulinemia, has been added to the MCE in the list of acceptable principal or secondary diagnosis codes associated with procedure codes 52.80, Pancreatic transplant, not otherwise specified, and 52.82, Homotransplant of pancreas.

Surgical Hierarchies (75FR50113)

In pre-MDCs, new MS-DRG 014 (Allogeneic Bone Marrow Transplant) has been reordered above MS-DRG 007 (Lung Transplant). New MS-DRG 015 (Autologous Bone Marrow Transplant) has been reordered above MS-DRG 010 (Pancreas Transplant).

In MDC 10, MS-DRG 614 (Adrenal and Pituitary Procedures with CC/MCC) and MS-DRG 615 (Adrenal and Pituitary Procedures without CC/MCC) have been reordered above MS-DRG 625 (Thyroid, Parathyroid and Thyroglossal Procedures with MCC).

Change to the Severity Level for Acute Renal Failure, Unspecified Diagnosis Code (75FR50116)

Code 584.9, Acute kidney failure, unspecified, has been changed from an MCC to a CC.

Changes to the ICD-9-CM Coding System (75FR50122)

In response to public comments, the following changes were made to the MS-DRG assignment or CC/MCC designation of new ICD-9-CM codes:

- Codes 488.01, Influenza due to identified avian influenza virus with pneumonia, and 488.11, Influenza due to identified novel H1N1 influenza virus with pneumonia, have been assigned to the pneumonia MS-DRGs (193-195) to be consistent with the MS-DRG definitions and classification of code 487.0, Influenza with pneumonia.

- Codes 780.33, Post traumatic seizures, and 278.03, Obesity hypoventilation syndrome, have been classified as CCs instead of non-CCs.

Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims (75FR50127)

CMS will be able to process up to 25 diagnosis codes and 25 procedure codes on hospital inpatient claims when received on the Version 5010 format starting on January 1, 2011. CMS is currently undergoing extensive system updates as part of the move to Version 5010, which includes the ability to accept ICD-10 codes. This complicated transition involves converting many internal systems prior to October 1, 2013, when ICD-10 will be implemented. One important step in this planned conversion process is the expansion of their ability to process additional diagnosis and procedure codes.

ICD-10 MS-DRGs (75FR50127)

During FY 2011, CMS will post Version 28.0 of the ICD-10 MS-DRGs based on the FY 2011 MS-DRGs. This version will include the CC Exclusion List.

The final version of the ICD-10 MS-DRGs to be implemented in FY 2014 will be subject to notice and comment rulemaking. In the meantime, CMS will provide extensive and detailed information on this activity through the ICD-9-CM Coordination and Maintenance Committee.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES (75FR50137)

FY 2011 Status of Technologies Approved for FY 2010 Add-On Payments (75FR50141)

Spiration[®] IBV[®] Valve System (75FR50141)

For FY 2011, in addition to making new technology add-on payments for cases of the Spiration[®] IBV[®] that map to MS-DRGs 163, 164, and 165 (with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49), CMS will make the new technology add-on payment for cases of the Spiration[®] IBV[®] that map to MS-DRGs 199, 200, and 201 with the presence of a diagnosis code of 512.1 in combination with procedure code 33.71 and 33.73. This determination will ensure that the hospital implanting the device receives the new technology add-on payment. In these cases, the transferring hospital performing the surgery will be subject to the transfer policy and would not receive the new technology add-on payment because it did not implant the device.

CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t)
(75FR50142)

New technology add-on payments for cases involving the TAH-t are being continued in FY 2011.

FY 2011 Applications for New Technology Add-On Payments (75FR50144)

Auto Laser Interstitial Thermal Therapy (AutoLITT™) System (75FR50144)

The AutoLITT™ has been approved for new technology add-on payments in FY 2011. The add-on payment is intended only for use of the device in cases of Glioblastoma Multiforme. Therefore, the new technology add-on payment is limited to cases involving the AutoLITT™ in MS-DRGs 25, 26, and 27. 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 procedure code 17.61, Laser interstitial thermal therapy (LITT) of lesion or tissue of brain under guidance, in combination with a primary diagnosis code that begins with a prefix of 191 (malignant neoplasm of brain).

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 (75FR50180)

Retirement of Quality Measures Under the RHQDAPU Program for the FY 2011 Payment Determination and Subsequent Years (75FR50186)

For the FY 2011 payment determinations and subsequent payment determinations, CMS has retired the Mortality for Selected Procedures Composite from the RHQDAPU (Reporting Hospital Quality Data for Annual Payment Update) program measures set, due to its unsuitability for comparative reporting.

Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program (75FR50188)

CMS finalized their proposal to select measures for three consecutive payment years in a single rulemaking in order to provide hospitals with advanced notice for planning purposes.

CMS indicated they will continue to pursue goals regarding the expansion and updating of quality measures under the RHQDAPU program while minimizing burden. They will take into account the public comments they received on the possible uses of electronic health records, registries, and all-payer claims data in the RHQDAPU program. CMS will

also consider the measure selection criteria suggested by various commenters in prioritizing and selecting quality measures for the future.

RHQDAPU Program Quality Measures for the FY 2012 Payment Determination
(75FR50192)

For the FY 2012 RHQDAPU program payment determination, 45 measures adopted for the FY 2011 payment determination are being retained.

Ten claims-based measures have been added to the RHQDAPU program measure set for the FY 2012 payment determination. Two of these measures are Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI) and eight are Hospital Acquired Condition (HAC) measures:

- PSI-11 (Postoperative Respiratory Failure)
- PSI-12 (Postoperative Pulmonary Embolism or Deep Vein Thrombosis)
- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma
- Vascular Catheter-Associated Infection
- Catheter-Associated Urinary Tract Infection
- Manifestations of Poor Glycemic Control

The RHQDAPU measure set for the FY 2012 payment determination can be found on page 50198 of the final rule.

RHQDAPU Program Quality Measures for the FY 2013 Payment Determination
(75FR50200)

For the FY 2013 RHQDAPU program payment determination, CMS is retaining all of the 55 quality measures adopted for the FY 2012 payment determination.

One new chart-abstracted measure, AMI (Acute Myocardial Infarction)-Statin prescribed at Discharge, has been added to the RHQDAPU program measure set for the FY 2013 payment determination.

One new Healthcare-Associated Infection (HAI) measure, Central Line Associated Blood Stream Infection (CLABSI), has been adopted for the measure set to be used for the FY 2013 RHQDAPU program payment determination. This measure is currently being collected by the Centers for Disease Control and Prevention (CDC) via the National Healthcare Safety Network (NHSN).

Data submission for both the AMI-Statin Prescribed at Discharge and CLABSI measures will begin with January 1, 2011 discharges.

The RHQDAPU measure set for the FY 2013 payment determination can be found on page 50208 of the final rule.

RHQDAPU Program Quality Measures for the FY 2014 Payment Determination
(75FR50210)

Four new chart-abstracted measures have been added to the RHQDAPU program measure set for the FY 2014 payment determination:

- Emergency Department (ED) Throughput – Admit Decision Time to ED Departure Time for Admitted Patients
- ED Throughput – Median Time from Emergency Department Arrival to ED Departure for Admitted Patients
- Global Flu Immunization
- Global Pneumonia Immunization

Measures PN-2 (Pneumococcal Vaccination Status) and PN-7 (Influenza Vaccination Status) are being retired from the RHQDAPU measure set for the FY 2014 and subsequent payment determinations because these measures overlap with the global immunization measures.

One new HAI measure, Surgical Site Infection (SSI), has been adopted for the measure set to be used for the FY 2014 RHQDAPU program payment determination. This measure is currently being collected by the Centers for Disease Control and Prevention (CDC) via the National Healthcare Safety Network (NHSN).

Data submission for the five new measures will begin with January 1, 2012 discharges.

All of the remaining FY 2013 measures will be retained for the FY 2014 payment determination.

The RHQDAPU measure set for the FY 2014 payment determination can be found on page 50212 of the final rule.

Synchronization of RHQDAPU Program Data Submission and Validation Quarters with Quarters Used to Make Payment Determinations (75FR50219)

Starting with the FY 2013 payment determination, CMS will determine whether hospitals meet the data submission requirement for quality measure data by looking at whether the hospital properly submitted data on the applicable measures during the same quarterly discharge periods. Specifically, the quarterly discharge periods that will apply to a particular payment determination will be the four quarters that occur within a calendar year.

With respect to CMS' requirement that hospital data be successfully validated in order for the hospital to earn the full payment update for a given fiscal year, CMS will validate four discharge quarters, but the quarters will be the 4th calendar quarter of the year that

occurs 2 years before the payment determination and the first 3 calendar quarters of the following calendar year, beginning with the FY 2013 payment determination. Thus, for the FY 2013 payment determination, CMS will validate data from the 4th calendar quarter of 2010 through the 3rd calendar quarter of 2011.

Procedures for Claims-Based Measures (75FR50222)

For the FY 2012 payment determination, CMS will use up to 3 years of discharges prior to January 1, 2011 (as appropriate for the measure), to calculate the 30-day mortality and 30-day readmission measures, AHRQ PSI, Inpatient Quality Indicator and Composite measures, and the proposed new HAC measures. For the FY 2013 and FY 2014 payment determinations, CMS will use up to 3 years of discharges (as appropriate for the measure) prior to January 1, 2012, and January 1, 2013, respectively. Hospitals are required to appropriately report the POA indicator in conjunction with ICD-9-CM coding to determine the presence of HACs so that the proposed HAC measures can be calculated for the RHQDAPU program using Medicare claims.

Data Submission Requirements for Structural Measures (75FR50223)

For the FY 2012 payment determination, hospitals should submit the required registry participation information once for the structural measures via a Web-based collection tool between July 1, 2011 – August 15, 2011 with respect to the time period of July 1, 2010 through December 31, 2010.

Data Submission and Reporting Requirements for HAI Measures Reported via NHSN (75FR50223)

Hospitals will submit the data elements needed to calculate the Central Line Associated Blood Stream Infection and Surgical Site Infection measures to the NHSN using the standard procedures that have been set forth by CDC for NHSN participation in general and for submission of these two measures to NHSN in particular. Hospitals will submit data for these two measures to CDC's NHSN on a monthly basis for discharges occurring on or after January 1, 2011.

For the FY 2013 payment determination, hospitals must submit HAI data via the NHSN for four consecutive calendar year (CY) discharge quarters as follows: 1Q CY 2011, 2Q CY 2011, 3Q CY 2011 and 4Q CY 2011.

For the FY 2014 payment determination, hospitals must submit HAI data for four consecutive calendar year discharge quarters as follows: 1Q CY 2012, 2Q CY 2012, 3Q CY 2012 and 4Q CY 2012.

Once quarterly each hospital will utilize an automated report function that will be made available to submitters in the NHSN, to generate a quarterly report containing hospital-level numerator, denominator, and exclusion counts for these two CDC measures specifically for the RHQDAPU program. The CDC will create this automated

RHQDAPU report function and add it to NHSN's reporting functionalities in the next few months. While hospitals may be reporting other data elements to CDC for other reporting programs, the quarterly RHQDAPU report that would be generated within NHSN would only contain those data elements needed to calculate the two measures being utilized in the RHQDAPU program. CMS will access the reports in the NHSN and will compile the reports for RHQDAPU program and public reporting purposes.

Chart Validation Requirements for Chart-Abstracted Measures (75FR50225)

For the FY 2012 payment determination, CMS will use the chart validation requirements and methods that were adopted for FY 2012 in the FY 2010 IPPS final rule.

For FY 2013 and future years, the same validation requirements were adopted as those adopted for the FY 2012 payment determination, with a couple of exceptions. For FY 2013 and future years, a targeting criterion has been added, CMS' random sample approach has been refined, and the data discharge quarters validated as part of the synchronization of RHQDAPU timelines have been changed.

Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years (75FR50229)

CMS has adopted their data accuracy and completeness acknowledgement requirements for the FY 2012 payment determination and subsequent years. However, hospitals are required to electronically acknowledge their data accuracy and completeness once between July 1, 2011 and August 15, 2011 for data to be used for the FY 2012 RHQDAPU program payment determination instead of the proposed July 1, 2010 through August 15, 2010 timeframe.

Electronic Health Records (EHRs) (75FR50231)

CMS is actively seeking to provide an alternative of EHR-based submission for RHQDAPU measures that otherwise would require chart or manual abstraction. Prior to accepting measures through EHRs for RHQDAPU, it would be necessary to assure that data submitted and results calculated are equivalent to that from chart or manual abstraction so that results would be reliable and consistent.

Some important RHQDAPU quality measures such as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) experience of care measures are based on survey data and do not lend themselves to EHR reporting. Similarly, certain outcome quality measures, such as the current RHQDAPU readmission measures, are based on claims rather than clinical data. Thus, not all RHQDAPU measures will necessarily be capable of being submitted through EHRs. As a consequence, not all RHQDAPU measures would necessarily be included in the HITECH EHR incentive program.

EHR Testing of Quality Measures Submission (75FR50232)

CMS believes the testing of EHR submission is an important and necessary step to establish the ability of EHRs to report clinical quality measures and the capacity of CMS to receive such data.

The electronic specifications and interoperability standards for EHR-based collection and transmission of the data elements for the ED Throughput, Stroke, and Venous Thromboembolism measures have been finalized by the Health Information Technology Standards Panel (HITSP) and are available for review and testing at <http://www.HITSP.org>. CMS anticipates 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 Venous Thromboembolism measures as early as summer of 2011.

HITECH Act EHR Provisions (75FR50233)

The RHQDAPU program and the HITECH Act have important areas of overlap and synergy with respect to the reporting of quality measures using EHRs. CMS believes the financial incentives under the HITECH Act for the adoption and meaningful use of certified EHR technology by hospitals will encourage the adoption and use of certified EHRs for the reporting of clinical quality measures under the RHQDAPU program.

For questions concerning this summary or the FY 2011 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 2011 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 16, 2010 issue of the *Federal Register* located at: <http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf>.

AHIMA's letter to CMS regarding the proposed rule for FY 2011 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/advocacy/comments.aspx>.