Analysis of Final Rule for FY 2007 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year (FY) 2007 revisions to the Medicare hospital inpatient prospective payment system (IPPS) was published in the August 18, 2006 issue of the *Federal Register*. This rule becomes effective on October 1, 2006. 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. The final rule can be reviewed in its entirety by downloading it from this link: http://www.access.gpo.gov/su_docs/fedreg/a060818c.html.

DRG REFINEMENTS BASED ON SEVERITY OF ILLNESS

No severity-adjusted DRG system will be implemented in FY 2007. While the Centers for Medicare & Medicaid Services (CMS) believes that the consolidated severity adjusted (CS) DRGs put forth in the proposed rule has the potential to improve the IPPS and account more completely for differences in severity of illness and associated costs among hospitals, they have several concerns about adopting it for FY 2007:

- **Further adjustments are needed to the proposed CS DRG system.** Adjustments need to be made to account for situations where less severely ill patients may be more resource-intensive because they need expensive medical technology. The CS DRGs assign a patient to a DRG based on severity of illness but do not recognize increased complexity due to the types of services/technology provided. Also, the CS DRGs do not incorporate many of the changes to the base DRG assignments that have been made over the years to the current CMS DRGs.
- **Use of a proprietary DRG system.** Commenters raised valid points about adopting a proprietary DRG system, including concerns about the availability, price and transparency of logic of the APR DRGs that are currently in use in Maryland (the CS DRGs are a variant of the APR DRG system). As CMS evaluates alternative severity classification systems, they will use public access to the system as an important element in evaluating whether the system can be adopted by Medicare. CMS will continue to strive to promote transparency in their decision-making as well as in future payment and classification systems as they have done in the past.
- **CMS did not evaluate alternative DRG systems (other than the APR DRG system) that could also better recognize severity.** Commenters suggested that alternative DRG systems can better recognize severity than the CS DRGs. Also, it

might be possible to update the severity DRG system that CMS developed in the mid-1990s. Under this option, CMS could continue their review of the complication/comorbidity (CC) list as part of their process of updating this severity DRG system.

CMS has engaged a contractor to assist them with completing an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs and meet other criteria that would make them suitable to adopt for purposes of payment under the IPPS. CMS expects to complete this evaluation this fall as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS rulemaking for FY 2008. CMS acknowledged that it is possible that some of the alternative systems included in this evaluation will be based on the current CMS DRGs. If CMS develops a clinical severity concept that uses the current CMS DRGs as the starting point, the issues raised by the healthcare industry during the public comment period for the proposed rule may no longer be a concern. If CMS decides to propose adoption of the CS DRGs for FY 2008, they would consider the issues raised by the commenters. They will also need to consider the application of the postacute care transfer policy if they adopt a new DRG system to better recognize severity for FY 2008.

As part of the process of evaluating alternative systems, CMS will consider updating the work they did in the mid-1990s to adapt a system developed by Yale University. This approach would have the advantage of using the current DRGs as a starting point and retaining the benefit of the many DRG decisions CMS has made in recent years. The severity DRG system developed by CMS in the 1990s used a base DRG with three levels of severity depending upon whether the patient had no CC, a CC, or a major CC.

CMS is concerned that a large increase in the number of DRGs, such as in the CS DRG system, will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under a system that better recognizes severity. Thus, more accurate and complete documentation and coding may occur under a DRG system that better recognizes severity because it will result in higher payments than the current CMS DRGs. CMS believes there may be a need for an adjustment to the standardized amount to account for improvements in documentation and coding that increase case mix, and thus, payments. If they decide to make such an adjustment, they will provide the specific level adjustment and the data and analysis underlying it in a proposed rule that will allow for an opportunity for public comment.

CMS has not proposed any changes to the DRG classifications used under other prospective payment systems that rely on the IPPS DRG classifications, such as the inpatient psychiatric facility PPS and long-term care hospital PPS. They will need to consider whether corresponding changes need to be made to these other payment systems once a final decision is made regarding adoption of a severity-adjusted DRG system under the IPPS.

SEVERITY REFINEMENT TO CURRENT CMS DRGS

CMS is taking steps toward transitioning the IPPS to a severity based DRG system for FY 2007 by applying some of the severity logic from their proposed CS DRG system to the current CMS DRGs where appropriate. By revising the current DRGs, CMS is offering hospitals an interim step toward severity DRGs. Hospitals will be able to take advantage of the improved recognition of severity within the context of the more familiar CMS DRGs. This interim step affords CMS the opportunity to adopt some of the more basic components of a severity DRG system, such as specific splits in DRGs that lead to groups with greater resource utilization.

These DRG modifications to better reflect severity will be applicable under other payment systems that rely on the IPPS DRG classifications, such as the inpatient psychiatric facility PPS and long-term care hospital PPS.

CMS identified 20 new DRGs involving 13 different clinical areas that would improve the current DRG system's recognition of severity of illness. These 20 new DRGs are constructed through a combination of approaches used in the proposed CS DRGs to refine the base DRGs, such as:

- Subdividing existing DRGs through the use of diagnosis codes.
- Subdividing DRGs based on specific surgical procedures.
- Selecting cases with specific diagnosis and/or procedure codes and assigning them to a new DRG which better accounts for their resource use and severity.

CMS also modified 32 DRGs to better capture differences in severity.

Nervous System Infection except Viral Meningitis (71FR47924)

DRG 20 (Nervous System Infection Except Viral Meningitis) has been deleted and DRGs 560 and 561 have been created to differentiate bacterial infection and tuberculosis from other infections of the nervous system. The diagnosis codes assigned to each new DRG can be found on pages 47925-47927 of the final rule.

Seizure and Headache (71FR47928)

DRGs 24 and 25 (Seizure & Headache Age >17 with and without CC, respectively) have been deleted and replaced with the following DRGs in order to separately classify seizures and headaches:

- DRG 562 (Seizure Age >17 with CC)
- DRG 563 (Seizure Age >17 without CC)
- DRG 564 (Headaches Age >17)

The data did not support creating a split based on the presence of a CC for headache cases.

The ICD-9-CM diagnosis codes assigned to these new DRGs can be found on page 47929 of the final rule.

Respiratory System Diagnosis with Ventilator Support (71FR47929)

DRG 475 (Respiratory System Diagnosis with Ventilator Support) has been deleted and new DRGs 565 and 566 have been created to differentiate mechanical ventilation that is less than 96 hours in duration from that greater than 96 hours.

Major Esophageal Disorders and Major Gastrointestinal and Peritoneal Infections (71FR47930)

Major esophageal disorders have been moved out of the various DRGs to which they were assigned and into new DRG 571 (Major Esophageal Disorders). Major gastrointestinal disorders and peritoneal infections have been moved out of the various DRGs to which they were assigned and into new DRG 572 (Major Gastrointestinal Disorders and Peritoneal Infections). The ICD-9-CM diagnosis codes classified to these 2 new DRGs can be found on pages 47931-47932 of the final rule.

Principal or Secondary Diagnosis of Major Gastrointestinal Diagnosis (71FR47933)

DRGs 148 (Major Small & Large Bowel Procedures with CC) and 154 (Stomach, Esophageal & Duodenal Procedures Age >17 with CC) have been subdivided based on the presence of a major gastrointestinal diagnosis. DRG 148 has been deleted and the following two new DRGs have been created:

- DRG 569 (Major Small & Large Bowel Procedures with CC with Major Gastrointestinal Diagnosis)
- DRG 570 (Major Small & Large Bowel Procedures with CC without Major Gastrointestinal Diagnosis)

DRG 569 has a principal diagnosis from MDC 6 (Diseases and Disorders of the Digestive System), a major gastrointestinal diagnosis as either the principal or secondary diagnosis, an operating room procedure code from DRG 148, and a CC. A list of the major gastrointestinal diagnoses can be found on pages 47933-47934 of the final rule.

DRG 570 has an operating room procedure code from DRG 148, a CC, and a principal diagnosis from MDC 6, except for a principal or secondary diagnosis on the "major gastrointestinal diagnosis" list.

DRG 154 has been deleted and the following two new DRGs have been created:

- DRG 567 (Stomach, Esophageal & Duodenal Procedures Age >17 with CC with Major Gastrointestinal Diagnosis)
- DRG 568 (Stomach, Esophageal & Duodenal Procedures Age >17 with CC without Major Gastrointestinal Diagnosis)

DRG 567 has a principal diagnosis from MDC 6, a major gastrointestinal diagnosis as either the principal or secondary diagnosis, an operating room procedure code from DRG 154, and a CC.

DRG 568 has an operating room procedure code from DRG 154, a CC, and a principal diagnosis from MDC 6, except for a principal or secondary diagnosis on the "major gastrointestinal diagnosis" list.

Major Bladder Procedures (71FR47935)

Major bladder procedures have been moved out of the various DRGs to which they were assigned (DRGs 303, 304, 305, 308, and 309) and into new DRG 573 (Major Bladder Procedures). The following DRGs have been renamed:

- DRG 303 (Kidney and Ureter Procedures for Neoplasm)
- DRG 304 (Kidney and Ureter Procedures for Non-Neoplasm with CC)
- DRG 305 (Kidney and Ureter Procedures for Non-Neoplasm without CC)

A list of the major bladder procedures can be found on page 47936 of the final rule.

Major Hematological and Immunological Diagnoses (71FR47936)

Major hematological and immunological diagnoses have been moved from DRGs 395, 396, 398, and 399 and into new DRG 574 (Major Hematological/Immunologic Diagnoses Except Sickle Cell Crisis and Coagulation Disorders). New ICD-9-CM codes 284.01, 284.09, 288.00, 288.01, 288.02, 288.03, 288.04, and 288.09 have also been assigned to this new DRG.

A list of the major hematological and immunological diagnoses assigned to DRG 574 can be found on pages 47937-47938 of the final rule.

O.R. Procedure for Patients with Infectious and Parasitic Diseases (71FR47938)

DRG 415 (O.R. Procedure for Patients with Infectious and Parasitic Diseases) has been deleted and two new DRGs created:

- DRG 578 (Infectious and Parasitic Diseases with O.R. Procedure)
- DRG 579 (Postoperative or Post-traumatic Infection with O.R. Procedure)

Cases will be assigned to DRG 578 if they were previously in DRG 415, but do not contain one of the following principal diagnosis codes:

- 958.3 (Posttraumatic wound infection, not elsewhere classified)
- 998.51 (Infected postoperative seroma)
- 998.59 (Other postoperative infection)
- 999.3 (Infection complicating medical care, not elsewhere classified)

Cases will be assigned to DRG 579 if they were previously assigned to DRG 415 and contain one of the four principal diagnosis codes listed above.

Severe Sepsis (71FR47938)

DRG 416 (Septicemia Age >17) has been deleted and the cases that had previously been assigned to this DRG will be split between two new DRGs, based on whether or not the patient is on mechanical ventilation for 96 or more hours:

- DRG 575 (Septicemia with Mechanical Ventilation 96+ Hours Age >17)
- DRG 576 (Septicemia without Mechanical Ventilation 96+ Hours Age >17)

Cases will be assigned to DRG 575 when they have a principal diagnosis from current DRG 416 and procedure code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more). Cases will be assigned to DRG 576 when they have a principal diagnosis from current DRG 416 and do not have code 96.72.

CHANGES TO SPECIFIC DRG CLASSIFICATIONS

Heart Transplant or Implant of Heart Assist System: Addition of Procedure to DRG 103 (71FR47939)

DRG 103 (Heart Transplant or Implant of Heart Assist System) has been reconfigured so that patients who have both the replacement of an external heart assist system (procedure code 37.63) and the explantation of that system (procedure code 37.64) prior to the hospital discharge will be assigned to DRG 103.

Pancreas Transplants (71FR47940)

Since Medicare has issued a final a national coverage determination stating that the performance of pancreas transplants alone is reasonable and necessary for Medicare beneficiaries in limited circumstances, the logic for the determination of patient case assignment to DRG 513 (Pancreas Transplant) has been changed to remove the requirement that patients have kidney disease. The list of diabetes mellitus codes required as a principal or secondary diagnosis, and the required operating room procedures, remains the same.

Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (71FR47940)

Cases involving the implantation of a dual array neurostimulator have been moved from DRGs 1 and 2 (Craniotomy Age >17 with and without CC, respectively) to DRG 543. DRG 543 will be re-titled “Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis.”

Carotid Artery Stents (71FR47942)

New DRG 583 (Carotid Artery Stent Procedure) has been created for cases involving insertion of a carotid artery stent. Procedure codes 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s)) and 00.63 (Percutaneous insertion of carotid artery stent(s)) must both be reported in order for cases to be assigned to DRG 583.

Medicare coverage of the carotid artery stent procedure is limited to patients at risk of developing a stroke due to narrowing or stenosis of the carotid artery. Diagnosis code 433.10 (Occlusion and stenosis of carotid artery without mention of cerebral infarction) should be used to identify the site of the procedure in the carotid artery. If there is a bilateral occlusion or stenosis, code 433.30 (Occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction) should be assigned as an additional diagnosis. In this situation, both codes 433.10 and 433.30 should be reported because code 433.30 includes arterial sites that are not currently covered by Medicare. Reporting of code 433.30 alone will cause the case to fail the editing system at the fiscal intermediary, and the case could be denied. Inclusion of the fifth digit of "1" (with cerebral infarction) with either code 433.1x or 433.3x will cause the claim to be rejected.

Insertion of Epicardial Leads for Defibrillator Devices (71FR47944)

The following procedure code combinations have been added to DRGS 515 (Cardiac Defibrillator Implant without Cardiac Catheterization, 535 (Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure, or Shock), and 536 (Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock) so that all types of defibrillator device and lead code combinations (37.74 + 00.54, 37.74 + 37.96, and 37.74 + 37.98) are included in these DRGs.

Hip and Knee Replacements (71FR47946)

Procedure codes that do not represent procedures that are bilateral or involve multiple major joints have been removed from DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity). These procedure codes are: 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55. These codes will be assigned to DRG 545 (Revision of Hip or Knee Replacement) when used either alone or in combination.

Medicare Code Editor Changes: Newborn Diagnoses (710FR47950)

Code 780.92 (Excessive crying of infant (baby)) has been added to the "Newborn Diagnoses edit in the Medicare Code Editor (MCE). To make a conforming change, this code is being removed from the "Pediatric Diagnoses – Age 0 Through 17" edit.

MCE Changes: Manifestations Not Allowed as Principal Diagnosis Edit (71FR47952)

The following diagnosis codes have been added to the "Manifestations Not Allowed as Principal Diagnosis" edit in the MCE:

- 362.03 (Nonproliferative diabetic retinopathy, NOS)
- 362.04 (Mild nonproliferative diabetic retinopathy)
- 362.05 (Moderate nonproliferative diabetic retinopathy)
- 362.06 (Severe nonproliferative diabetic retinopathy)
- 362.07 (Diabetic macular edema)

MCE Changes: Nonspecific Principal Diagnosis (71FR47952)

Code 770.10 (Fetal and newborn aspiration, unspecified) has been added to the "Nonspecific Principal Diagnosis" edit in the MCE because it was inadvertently omitted last year when the code was created.

MCE Changes: Nonspecific Operating Room Procedure Edit (71FR47953)

Code 00.29 (Intravascular imaging unspecified vessel(s)) has been removed from the "Nonspecific Operating Room Procedure" edit in the MCE. This code was erroneously placed in this edit, as it does not represent an operating room procedure.

Code 68.39 (Other subtotal abdominal hysterectomy) has also been removed from the "Nonspecific Operating Room Procedure" edit, as it was also included in this edit in error.

MCE Changes: Non-Covered Procedures (71FR47953)

Changes to the "Non-Covered Procedures" edit have been made to be consistent with the changes made to DRG 513 (Pancreas Transplant) as a result of a Medicare national coverage determination concerning pancreas transplants.

Also as a result of a Medicare national coverage determination, code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) has been added to the "Non-Covered Procedures" edit except when the patient is 60 years of age or less.

MCE Changes: Bilateral Procedures (71FR47954)

The following codes have been removed from the "Bilateral Procedures" edit, as these are adjunct codes, and not recognized by the DRG GROUPER as procedures, and so they were included in the edit in error:

- 00.74 (Hip replacement bearing surface, metal-on-polyethylene)

- 00.75 (Hip replacement bearing surface, metal-on-metal)
- 00.76 (Hip replacement bearing surface, ceramic-on-ceramic)

The following codes have also been deleted from the "Bilateral Procedures" edit because they were erroneously included in this edit:

- 00.71 (Revision of hip replacement, acetabular component)
- 00.72 (Revision of hip replacement, femoral component)
- 00.73 (Revision of hip replacement, acetabular liner and/or femoral head only)
- 00.81 (Revision of knee replacement, tibial component)
- 00.82 (Revision of knee replacement, femoral component)
- 00.83 (Revision of knee replacement, patellar component)
- 00.84 (Revision of total knee replacement, tibial insert (liner))
- 81.53 (Revision of hip replacement not otherwise specified)
- 81.55 (Revision of knee replacement not otherwise specified)

Note: See pages 47950-47953 in the final rule for details concerning the addition of new and revised ICD-9-CM codes to the MCE edits.

Changes to Surgical Hierarchy (71FR47955)

The list of changes to the surgical hierarchies can be found on page 47955 of the final rule.

Comprehensive Review of the CC List (71FR47955)

CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Although they did not complete this review because of the work they did to develop the CS DRGs, they are considering whether to continue their analysis of the CC list as part of the effort to develop and adopt a severity DRG system that is in the public domain for FY 2008. CMS may update the work they did to develop a severity DRG system in the mid-1990s that classified patients into a base DRG that was further subdivided based on three levels of severity depending on whether the patient had no CC, a CC, or a major CC in conjunction with continuing their review of the CC list.

Moving Procedure Codes from DRG 468 to MDCs (71FR47957)

The following two procedure codes have been moved from DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis) into DRGs 479 (Other Vascular Procedures without CC), 553 (Other Vascular Procedures with CC with Major Cardiovascular Diagnosis), and 554 (Other Vascular Procedures with CC without Major Cardiovascular Diagnosis):

- 04.92 (Implantation or replacement of peripheral neurostimulator lead(s))
- 86.96 (Insertion or replacement of other neurostimulator pulse generator)

Changes to the ICD-9-CM Coding System (71FR47957)

Based on comments received in response to the proposed rule, the DRG assignment for diagnosis codes 629.81 (Habitual aborter without current pregnancy) and 629.89 (Other specified disorders of female genital organs) has been changed from DRG 368 (Infections, Female Reproductive System) to DRG 369 (Menstrual and Other Female Reproductive System Disorders).

Other Issues: Chronic Kidney Disease (71FR47960)

The DRG classification for the following three codes has been changed from DRGs 331 (Other Kidney and Urinary Tract Diagnoses, Age Greater than 17 with CC), 332 (Other Kidney and Urinary Tract Diagnoses, Age Greater than 17 without CC), and 333 (Other Kidney and Urinary Tract Diagnoses, Age 0-17) to DRGs 315 (Other Kidney and Urinary Tract Procedures) and 316 (Renal Failure):

- 403.00 (Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified)
- 403.10 (Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified)
- 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified)

This change has been made in order to assign these codes to the same DRGs as other chronic kidney disease codes.

Other Issues: Devices that are Replaced Without Cost or Where Credit for a Replaced Device is Furnished to the Hospital (71FR47962)

CMS is taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harmful device-related effects on the health of Medicare patients and the public in general. They believe they need to consider whether it is appropriate to reduce the Medicare payment in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. Such a proposal could cover certain devices for which credit for the replaced device is given or which are replaced as a result of, or pursuant to, a warranty, field action, voluntary recall, involuntary recall, and certain devices which are provided free of charge. It could provide for a reduction in the IPPS payment when CMS determines that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device.

CMS will need to develop a methodology to determine the amount of the reduction to the otherwise payable IPPS payment. They believe this is appropriate because in these cases the full cost of the replaced device is not incurred and, therefore, a payment adjustment is necessary to remove the cost of the device.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES

Kinetra® – Implantable Neurostimulator for Deep Brain Stimulation (71FR47999)

Add-on payments for the Kinetra® implantable neurostimulator have been discontinued.

Endovascular Graft Repair of the Thoracic Aorta (71FR47999)

Add-on payments for endovascular graft repair of the thoracic aorta (GORE TAG) will continue for FY 2007.

Restore® Rechargeable Implantable Neurostimulator (71FR48000)

Add-on payments for the Restore® rechargeable implantable neurostimulator will continue for FY 2007.

X STOP Interspinous Process Decompression System (71FR48002)

The X STOP interspinous process decompression system has been approved for a new technology add-on payment for FY 2007. ICD-9-CM procedure code 84.58 (Implantation of interspinous process decompression device) should be assigned for cases involving this device.

REPORTING OF HOSPITAL QUALITY DATA FOR ANNUAL HOSPITAL PAYMENT UPDATE (71FR48029)

Hospitals are now required to submit data on a specified expanded set of 21 quality measures to the Quality Improvement Organization (QIO) Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). Thee deadline for hospitals to submit this data for third calendar quarter of 2006 is February 15, 2007.

CMS has taken steps to ensure that the burden on hospitals to submit data on the expanded measures is as minimal as possible. For example, in addition to being described in the final rule, all of the measures that must be reported are described in the "Specifications Manual for National Hospital Quality Measures," which is a manual that is jointly issued and maintained by CMS and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The manual contains all of the specifications, data definitions, data collection rules and algorithms related to all 21 measures.

For the FY 2007 update, and until further notice, CMS will continue to require that hospitals meet the chart validation requirements that they implemented in the FY 2006 IPPS final rule.

CMS has encouraged hospitals to take steps toward the adoption of electronic health records (EHRs) that will allow for reporting of clinical quality data from the EHRs directly to a CMS data repository. They intend to begin working toward creating measures specifications and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as is currently done. After consideration of the public comments received in response to the FY 2007 proposed rule, CMS will continue to pursue the adoption of electronic health records for the reporting of hospital quality data.

VALUE-BASED PURCHASING (71FR48045)

CMS is examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. They will be hosting public listening sessions in 2007 to receive public input on drafts of their plan for Medicare hospital value-based purchasing.

Considerations Related to Certain Conditions, Including Hospital-Acquired Infections (71FR48051)

By October 1, 2007, the Secretary is required by law (the Deficit Reduction Act of 2005) to identify at least two conditions that are:

- High cost or high volume or both,
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
- Could reasonably have been prevented through the application of evidence-based guidelines.

For discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present.

The Deficit Reduction Act also requires hospitals to submit the secondary diagnoses that are present on admission when reporting payment information for discharges on or after October 1, 2007.

CMS will be working closely with the Centers for Disease Control and Prevention over the coming months to select appropriate conditions to propose for implementation. Watch for further information in the FY 2008 IPPS proposed rule, which will be published in the spring of 2007.

Promoting Effective Use of Health Information Technology (71FR48053)

CMS recognizes the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. They believe that value-based purchasing can encourage hospitals to invest in activities, such as effective HIT, that have the potential to improve quality and decrease unnecessary costs. Effective use of HIT can be used to decrease the burden of reporting to value-based purchasing programs.

At this time, CMS is not adopting their proposal to require adoption of certified, interoperable HIT as a Medicare Condition of Participation. They are reserving judgment on the imposition of such a requirement and will continue to research the feasibility of doing so.

For questions concerning this summary or the FY 2007 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 2007 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 18, 2006issue of the *Federal Register* located at: http://www.access.gpo.gov/su_docs/fedreg/a060818c.html.

AHIMA's letter to CMS regarding the proposed rule for fiscal year 2007 revisions to the Medicare hospital inpatient prospective payment system can be found on the Policy and Government Relations section of the AHIMA web site: http://www.ahima.org/dc/.