



Analysis of Final Rule for FY 2009 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year (FY) 2009 revisions to the Medicare hospital inpatient prospective payment system (IPPS) was published in the August 19, 2008 issue of the *Federal Register*. This rule became effective on October 1, 2008. 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/a080819c.html.

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

MS-DRG RECLASSIFICATIONS

General (73FR48443)

Commenters expressed concern that only 9 diagnosis and 6 procedure codes are used by Medicare to process each claim under the IPPS. The commenters stated that the implementation of new initiatives, such as the MS-DRG system, present on admission reporting, and the hospital-acquired payment provision, depend on the capturing of all of the patient's diagnoses and procedures in order to fully represent the patient's severity of illness, complexity of care, and quality of care provided. The Centers for Medicare & Medicaid Services (CMS) agree with the commenters that there is value in retaining additional data on patient conditions that would result from expanding Medicare's data system so it can accommodate additional diagnosis and procedure codes. They have been considering this issue while contemplating refinements to the DRG system to better recognize patient severity of illness. However, extensive lead time is required to allow for modifications to their internal and contractors' electronic systems in order to process and store this additional information. CMS is unable to currently move forward with this recommendation without carefully evaluating implementation issues. However, they will continue to carefully evaluate this request to expand the process capacity of their systems.

MS-DRG Documentation and Coding Adjustment (73FR48447)

A documentation and coding adjustment of -0.9 percent has been applied to the FY 2009 IPPS national standardized amount. Since the documentation and coding adjustments established in the FY 2008 IPPS final rule are cumulative, the -0.9 percent documentation and coding adjustment in FY 2009 is in addition to the -0.6 percent adjustment in FY 2008, yielding a combined effect of -1.5 percent.

A number of commenters disagreed with the need for the documentation and coding adjustment. Several commenters suggested that the documentation and coding adjustment is intended to address inappropriate upcoding, where a hospital's coding is not justified by the medical record. The commenters suggested that CMS undertake studies to identify inappropriate coding by individual providers.

CMS does not believe there is anything inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment, as long as the coding is fully and properly supported by documentation in the medical record. CMS noted that as required by law, they are applying the statutorily specified documentation and coding adjustment to the FY 2009 national standardized amount. The documentation and coding adjustment was developed based on the recognition that the MS-DRGs, by better accounting for severity of illness in Medicare payment rates, would encourage hospitals to ensure they had fully and accurately documented and coded all patient diagnoses and procedures consistent with the medical record in order to garner the maximum IPPS payment available under the MS-DRG system. DRG recalibration is required to be budget neutral. Due to the standard 2-year lag in claims data, when the MS-DRGs were recalibrated in FY 2008, the calculations were based on FY 2006 claims data that reflected coding under the prior CMS DRG system. As a result, the claims data upon which the DRG recalibrations were performed in FY 2008 did not reflect any improvements in documentation and coding encouraged by the MS-DRG system. CMS' actuaries determined that a separate adjustment for documentation and coding improvements would be needed in order to ensure that the implementation of the MS-DRG system was budget neutral.

PREVENTABLE HOSPITAL-ACQUIRED CONDITIONS (HACS), INCLUDING INFECTIONS (73FR48471)

HACs Selected During FY 2008 IPPS Rulemaking and Changes to Certain Codes (73FR48473)

The conditions that were selected for the HAC payment provision through the FY 2008 IPPS final rule are listed in the table below:

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign body retained after surgery	998.4 or 998.7
Air embolism	999.1

Selected HAC	CC/MCC (ICD-9-CM Codes)
Blood incompatibility	999.6
Pressure ulcer stages III & IV	707.23 or 707.24
Falls and trauma: fracture, dislocation, intracranial injury, crushing injury, burn, electric shock	Codes within these ranges on the CC/MCC list: 800-829, 830-839, 850-854, 925-929, 940-949, 991-994
Catheter-associated urinary tract infection	996.64 (also excludes the following from acting as a CC/MCC: 112.2, 590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0)
Vascular catheter-associated infection	999.31

The HAC payment provision implications for the selected HACs listed above took effect on October 1, 2008.

Candidate HACs (73FR48474)

CMS and the Centers for Disease Control and Prevention (CDC) have worked together diligently and with other stake holders to identify and select candidates for the HAC payment provision. The additional candidate HACs selected in the FY 2009 final rule have payment implications beginning October 1, 2008.

Additional Selected HAC	CC/MCC (ICD-9-CM codes)
Manifestations of poor glycemic control	One of these diagnosis codes: 250.10-250.13, 250.20-250.23, 251.0, 249.10-249.11, 249.20-249.21
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	519.2 + one of these procedure codes: 36.10-36.19
Surgical site infection following certain orthopedic procedures	996.67 or 998.59 + one these procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, 81.85
Surgical site infection following bariatric surgery for obesity	Principal diagnosis: 278.01 + 998.59 + one of these procedure codes: 44.38, 44.39, 44.95
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures	One of these diagnosis codes: 415.11, 415.19, 453.40-453.42 + one of these procedure codes: 00.85-00.87, 81.51-81.52, 81.54

Present on Admission Indicator Reporting (POA) (73FR48486)

The HAC payment provision will apply when POA indicator “N” (not present on admission) or “U” (documentation is insufficient to determine if the condition was present on admission) is reported. This means the CC/MCC MS-DRGs will not be paid for HACs coded with the “N” or “U” POA indicators. CMS believes that including “U”

in the HAC payment provision will encourage better documentation and will result in more accurate public health data.

CMS plans to analyze whether both the “N” and “U” POA reporting options are being used appropriately. They noted that AHIMA’s Standards of Ethical Coding require accurate coding regardless of the payment implications of the diagnoses. Diagnoses and POA indicators must be reported accurately on claims regardless of the fact that diagnoses coded with an “N” or “U” may no longer trigger a higher paying MS-DRG. Medicare program integrity initiatives closely monitor for inaccurate coding and coding inconsistent with medical record documentation.

CMS recognizes that there may be some exceptional circumstances under which payment might be made when the “U” POA indicator is reported. Death, elopement (leaving against medical advice), and transfers out of a hospital may preclude making an informed determination of whether a HAC was present on admission. The extent to which and under what circumstances the “U” POA indicator is used will be monitored. In the future, CMS may consider proposing use of the patient discharge status codes to recognize exceptions for payment.

CHANGES TO SPECIFIC MS-DRG CLASSIFICATIONS

Artificial Heart Devices (73FR48491)

Code 37.52, Implantation of total internal biventricular heart replacement system, has been assigned to MS-DRGs 001, Heart Transplant or Implant of Heart Assist System with Major Comorbidity or Complication (MCC), and 002, Heart Transplant or Implant of Heart Assist System without Major Comorbidity or Complication (MCC).

Code 37.52 has been removed from the “Non-Covered Procedure” edit and assigned to the “Limited Coverage” edit. This means that implantation of an artificial heart in a Medicare beneficiary will be covered when the implanting facility has met the criteria as set forth by CMS. Both procedure code 37.52 and diagnosis code V70.7, Examination of participant in clinical trial, must be present on the claim in order for the claim to be considered a covered Medicare service.

Transferred Stroke Patients Receiving Tissue Plasminogen Activator (tPA) (73FR48493)

CMS will monitor the cases of patients suffering a stroke who are evaluated and given tPA in a community hospital’s emergency department and then are transferred to another facility. In the future, they will evaluate their data for potential MS-DRG reassignment based on the use of the new diagnosis code, V45.88, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility. Receiving hospitals are strongly encouraged to include this code on appropriate claims.

Automatic Implantable Cardioverter-Defibrillators (AICD) Lead and Generator Procedures (73FR48496)

The title of MS-DRG 245 has been revised to read “AICD Generator Procedures,” which includes procedure codes 37.96, Implantation of automatic cardioverter/defibrillator pulse generator only, 37.98, Replacement of automatic cardioverter/defibrillator pulse generator only, and 00.54, Implantation or replacement of cardiac resynchronization defibrillator pulse generator device only [CRT-D]. New MS-DRG 265, AICD Lead Procedures, has been created and will include procedure codes 37.95, Implantation of automatic cardioverter/defibrillator lead(s) only, 37.97, Replacement of automatic cardioverter/defibrillator lead(s) only, and 00.52, Implantation or replacement of transvenous lead [electrode] into left ventricular coronary venous system.

Hip and Knee Replacements and Revisions (73FR48498)

The American Association of Hip and Knee Surgeons (AAHKS) recommended a number of complicated, interrelated changes to the joint procedure MS-DRGs. CMS has not yet had the opportunity to review data for these cases under the new MS-DRGs. They analyzed the impact of the recommendations using cases prior to the implementation of MS-DRGs. The recommendations were difficult to analyze because there were so many separate logic changes that impacted a number of MS-DRGs. CMS examined each major suggestion separately and found that their data and clinical analysis did not support making the suggested changes. No revisions to the joint procedure MS-DRGs are being made for FY 2009. However, CMS plans to examine the issues presented by the AAHKS once they receive data under the MS-DRG system. They also welcome additional recommendations from the AAHKS and others on a more incremental approach to resolving its concerns about the ability of the current MS-DRGs to adequately capture differences in severity levels for joint procedure patients.

Severe Sepsis (73FR48507)

The MS-DRG titles for MS-DRGs 870, 871, and 872 have been revised to include the term “severe sepsis.” The revised titles read as follows:

- MS-DRG 870, Septicemia or Severe Sepsis with Mechanical Ventilation 96+ Hours;
- MS-DRG 871, Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC;
- MS-DRG 872, Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC.

It was felt that modification of the MS-DRG titles would assist in quality improvement efforts and provide a better reflection on the types of patients included in these MS-DRGs.

Traumatic Compartment Syndrome (73FR48508)

Traumatic compartment syndrome codes 958.90-958.99 have been added to MS-DRGs 963 (Other Multiple Significant Trauma with MCC) and 965 (Other Multiple Significant Trauma without CC/MCC). These ICD-9-CM codes were inadvertently omitted from the multiple trauma MS-DRGs last year.

Medicare Code Editor (MCE) Changes: List of Unacceptable Principal Diagnoses (73FR48509)

Diagnosis code V62.84, Suicidal ideation, has been removed from the MCE list of “Unacceptable Principal Diagnoses,” since the FY 2009 version of the *ICD-9-CM Official Guidelines for Coding and Reporting* indicates that this code is acceptable as a principal or secondary diagnosis.

MCE Changes: Diagnoses Allowed for Males Only (73FR48509)

The following codes have been added to the MCE edit of diagnosis allowed for males only:

- 603.0, Encysted hydrocele;
- 603.1, Infected hydrocele;
- 603.8, Other specified types of hydrocele;
- 603.9, Hydrocele, unspecified.

These codes had inadvertently been omitted from this MCE edit.

MCE Changes: Limited Coverage Edit (73FR48509)

Procedure code 37.52, Implantation of internal biventricular heart replacement system, has been removed from the MCE “Non-Covered Procedure” edit and assigned to the “Limited Coverage” edit. To comply with the coverage policy, both code 37.52 and code V70.7, Examination of participant in clinical trial, must be present on the claim. Medicare claims that do not have both codes will be denied, retroactive to May 1, 2008 (the date of the coverage decision memorandum).

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES

FY 2009 Applications for New Technology Add-On Payments (73FR48554)

CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH-t) **(73FR48555)**

CMS has approved the CardioWest™ temporary Total Artificial Heart system (TAH-t) for FY 2009 new technology add-on payment. This system offers a new treatment option that previously did not exist for patients with end-stage biventricular failure. However,

the TAH-t's Medicare coverage is limited to approved clinical trial settings, and the new technology add-on payment status does not negate the restrictions under the national coverage determination nor does it obviate the need for continued monitoring of clinical evidence for the TAH-t. The new technology add-on payment for FY 2009 will be triggered by the presence of ICD-9-CM procedure code 37.52, Implantation of total heart replacement system, diagnosis code V70.7, Examination of participant in clinical trial, and condition code 30, Qualifying Clinical Trials.

The other three applications for technology add-on payment status were not approved.

CMS has established a deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval in order to be fully evaluated in the applicable IPPS final rule each year.

Reporting of Hospital Quality Data for Annual Hospital Payment Update: Background (73FR48597)

The addition of the following three quality measures brings the total number of measures used for FY 2009 annual payment determination to thirty:

- Pneumonia 30-day Mortality Measure;
- Surgical Care Improvement Project (SCIP) Infection 4: Cardiac Surgery Patients with Controlled 6 AM Postoperative Serum Glucose;
- Surgical Care Improvement Project (SCIP) Infection 6: Surgery Patients with Appropriate Hair Removal

Quality Measures for the FY 2010 Payment Determination and Subsequent Years (73FR48602)

The Pneumonia Oxygenation Assessment measure has been removed from the IPPS quality measure set. Hospitals no longer have to submit data on this measure beginning with January 1, 2009 discharges. CMS noted that the vast majority of hospitals are performing near 100 percent on this measure. Oxygenation assessment is routinely performed by hospitals for admitted patients without regard to the specific diagnosis.

Two measures have been updated to reflect National Quality Forum (NQF) changes in the applicable timing intervals:

- Acute Myocardial Infarction – Primary Percutaneous Coronary Intervention (PCI) received within 90 minutes of hospital arrival;
- Pneumonia – Initial antibiotic received within 6 hours of hospital arrival.

CMS has decided to adopt only one of the four proposed nursing sensitive measures, the Failure to Rescue measure, for the FY 2010 payment determination, due to the fact that these measures are still undergoing field testing and the other three proposed measures require chart abstraction. The Failure to Rescue measure can be calculated using Medicare claims data and does not require submission of patient-level data. The claims data that will be used to calculate this measure, as well as all the Medicare claims based

measures for the FY 2010 payment determination, will be from July 1, 2007 through June 30, 2008 (3rd quarter 2007 discharges through 2nd quarter 2008 discharges).

Only one of the three proposed readmission measures, Heart Failure 30-Day Risk Standardized Readmission Measure, was adopted in the FY 2009 IPPS final rule. CMS intends to adopt the Heart Attack 3-Day Risk Standardized Readmission Measure and the Pneumonia 30-Day Risk Standardized Readmission Measure for the FY 2010 payment determination in the Calendar Year 2009 Hospital Outpatient Prospective Payment System final rule, contingent upon endorsement from a national consensus-based entity such as the NQF.

None of the six proposed venous thromboembolism measures have been adopted for the FY 2010 payment determination, even though they have received NQF endorsement. These measures would require submission of chart-abstracted data for which current submission mechanisms will not be available for use for the FY 2010 payment determination. CMS intends to propose these measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination. They also intend to explore whether data needed to calculate these measures could be submitted using electronic health records (EHRs).

None of the five proposed stroke measures have been adopted for the FY 2010 payment determination because they have not yet been endorsed by NQF. CMS intends to propose these measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination.

The following Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) and Inpatient Quality Indicators (IQIs) have been adopted in the FY 2009 final rule:

- PSI 4 – Death among surgical patients with treatable serious complications;
- PSI 6 – Iatrogenic pneumothorax, adult;
- PSI 14 – Postoperative wound dehiscence;
- PSI 15 – Accidental puncture or laceration;
- IQI 4 and 11 – Abdominal aortic aneurysm mortality rate (with or without volume);
- IQI 19 – Hip fracture mortality rate;
- IQI Mortality for selected medical conditions (composite);
- IQI Mortality for selected surgical procedures (composite);
- IQI Complication/patient safety for selected indicators (composite).

These are claims-based outcome measures that can be calculated for hospital inpatients without the burden of additional chart abstraction. CMS had decided to initially calculate them based on existing Medicare claims data. CMS considered requiring submission of all-payer claims data, but many hospitals submit this data to other entities already and it would be burdensome to expect them to submit the same data separately to CMS. However, CMS is still interested in collecting all-payer claims data for the AHRQ outcome measures and may propose to collect such data in the future.

One out of 15 proposed cardiac surgery measure, Participation in a Systematic Database for Cardiac Surgery, has been adopted for the FY 2010 payment determination. This is a structural measure which requires reporting whether the hospital participates in a cardiac surgery registry, but does not require that hospitals actually participate in a registry. Hospitals that do not currently report to a registry will not be required to do so and will not be penalized for not participating in a registry. The data submission window for this measure will be from July 1, 2009 to August 15, 2009. CMS did not finalize the other 14 process and outcome measures that they had proposed to collect from the Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry due to hospitals' concerns about the perceived requirement to participate specifically in the STS registry and because they have not yet established the infrastructure to collect these measures directly from hospitals. CMS intends to propose the other 14 cardiac surgery measures during the FY 2010 IPPS rulemaking cycle for the FY 2011 payment determination. They will consider the best alternative for data collection for the other STS measures and whether the data should be received from the STS registry or submitted directly to CMS.

In summary, one of the 30 current measures is being retired and 13 new measures are being added for the FY 2010 payment determination, resulting in a total of 42 measures.

Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program (73FR48613)

In looking forward to further expansion of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, CMS believes it is important to take several goals into consideration:

- Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and experience-of-care measures;
- Expanding the scope of hospital services to which the measures apply;
- Considering the burden on hospitals in collecting chart-abstracted data;
- Harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality;
- Seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being broadly reported by hospitals, such as clinical data registries or all-payer claims databases; and
- Weighing the meaningfulness and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program.

CMS intends to work to simplify the data abstraction specifications that add to the burden of data collection and to explore mechanisms for data submission using electronic health records. They are also actively pursuing alternative data sources, including data sources that are electronically maintained. Alternative data submission methodologies under consideration include:

- Use of registry-collected clinical data;

- Use of data collected by State data organizations, State hospital associations, Federal entities such as AHRQ, and/or other data warehouses;
- Use of the CMS Continuity Assessment Record & Evaluation (CARE) tool; and
- Submission of data derived from electronic versions of laboratory test reports that are issued by the laboratory to the ordering provider and maintained by the hospital as part of the patient's medical record.

Data Attestation Requirements for FY 2009 (73FR48624)

CMS has decided to defer a requirement in FY 2009 for hospitals to separately attest to the accuracy and completeness of their submitted data, due to the burden placed on hospitals to report paper attestation forms on a quarterly basis.

Electronic Health Records (73FR48626)

CMS intends 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. They will work toward developing new measures that are less burdensome for hospitals to report and more easily utilize electronic medical records.

For questions concerning this summary or the FY 2009 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 2009 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 19, 2008 issue of the *Federal Register* located at: http://www.access.gpo.gov/su_docs/fedreg/a080819c.html.

AHIMA's letter to CMS regarding the proposed rule for fiscal year 2009 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/>.