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FY09 CMS IPPS Update

Audio Seminar / Webinar

September 25, 2008

Practical Tools for Seminar Learning

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Faculty

Karen Scott, Med, RHIA, CCS-P, CPC

Karen Scott has over 20 years experience in the healthcare field. Ms. Scott is the owner of Karen Scott Seminars and Consulting, through which she teaches seminars on coding, reimbursement, medical terminology, and management throughout the country. She has been an educator for many years, and has two AHIMA publications: Coding and Reimbursement for Hospital Inpatient Services and Medical Coding for the Non-Coder: Understanding Coding and Reimbursement in Today's Healthcare Society.

Joy J. King, RHIA, CCS

Joy J. King has her own consulting firm, Joy King Consulting, LLC. Ms. King has over 20 years of experience in HIM, with emphasis on inpatient coding. Prior to starting her own consulting firm, she directed the HIM department in several hospitals in Birmingham, AL, and served as a consultant for the Alabama Quality Assurance Foundation and Florida Medical Quality Assurance, Inc. Ms. King has also taught coding workshops and is a frequent presenter on clinical documentation as it impacts coding and reimbursement to hospital medical staffs.

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Agenda

- **Summarize the Medicare FY09 MS-DRG System as it relates to:**
  - **Changes to Specific MS-DRG Classifications**
  - **Medicare Code Editor Changes**
  - **ESRD and New Technology Add-On Payments**
  - **Reporting of Hospital Quality Data**

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Number of Codes Accepted?

- **Comments (again) regarding HIPAA compliance**
  - **25 diagnoses 25 procedures**
  - **Medicare accepts 9 dx 6 px**
  - **Still not changing requirements**

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Documentation and Coding Adjustment

- **MS-DRG system**
  - **Increased number of DRGs (from 538 in FY 2007 to 745 in FY 2008)**
  - **More "fully taking into account severity of illness"**
  - **Encourages hospitals to improve documentation and coding**
  - **System has "potential" to lead to increases in payments without increase SOI**

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Documentation and Coding Adjustment (cont.)

- **Requires adjustment of -0.9% (not -1.8% noted last year) to national standardized amount**
- **Cumulative Last year -0.6 + this year -0.9 = -1.5% total**
- **Plan to add to this next year**
  - **Review if will be applied to hospital specific rates for FY 2010**
- **Possible other payment adjustments 2010-2012 based on review of claims data, case mix changes data**

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MS-DRGs Impact on CMI

- **Will analyze shifts *among* base DRGs (due to changes in PDx)**
- **Will analyze shifts *within* base DRGs (due to changes in secondary Dx)**
- **May also use historical data from Hospital Payment Monitoring Program (HPMP) monitored by QIOs**
- **Proposal for adjustments FY 2010 – 2012 will be subject to public comments**

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Transition of Weights

- ***2-year transition to coincide with transition to cost-based relative weights (r.w.)***
  - **FY 2008, r.w. a blend of 50% current DRG and 50% MS-DRG r.w.**

+

  - **2/3 cost-based / 1/3 charge-based r.w.**
  - **FY 2009, 100% cost-based, 100% MS-DRG r.w.**

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Notes/Comments/Questions

Refinement of Relative Weights

- Discussion on use of revenue codes (RC) to validate services in right location on cost report
- High vs. low cost supplies
- Implantable devices charged to patients
  - RC 0275 pacemaker
  - RC 0276 Intraocular lens
  - RC 0278 Other implants
  - RC 0624 Investigational Device
  - May ask NUBC to establish additional revenue codes

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MS-DRG Title Changes

- New Title: 154 Other Ear, Nose, Mouth and Throat Diagnoses with MCC
  - Previous Title: Trauma and Deformity with MCC
- 155 Other Ear, Nose, Mouth and Throat Diagnoses with CC
  - Nasal Trauma and Deformity with CC
- 156 Other Ear, Nose, Mouth and Throat Diagnoses without CC/MCC
  - Nasal Trauma and Deformity without CC/MCC

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More Title Changes

- **250 Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC**
  - **Percutaneous Cardiovascular Procedure without Coronary Artery Stent**
- **251 Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC**
  - **Percutaneous Cardiovascular Procedure without Coronary Artery Stent or AMI without MCC**
- **864 Fever**
  - **Fever of Unknown Origin**

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Charge-Based to Cost-Based

Implementation over 3 years

- **3rd Yr: Weights based on 100% Costs**
- **RTI hired to investigate proposed HSRV method problem of "charge compression" – CMS implemented national CCRs for 15 Cost centers**
- **RAND hired to investigate HSRVs vs. CCRs in relation to MS-DRGs, including current relative weight methodology & five others**

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Specific MS-DRG Changes

- **Artificial Heart Devices**
- **Used for severe failure of both rt and lt ventricles (biventricular failure)**
- **4000 pts per year need transplant**
- **Only 2000 available**
- **Ventricular assist devices (VADs) surgically attached to native ventricles**
- **37.52 was on non-covered list**

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NCD to cover artificial hearts

- **Now using artificial hearts as bridge to transplantation**
  - **End stage heart failure**
  - **Risk for imminent death**
  - **TAH-t Temporary Total Artificial Heart**
  - **Used for inpatient only**
  - **AbioCor System**
    - **FDA approved for end stage patients not candidates for transplant, less than 75 years old, on multiple inotropic support, not tx by VAD destination therapy, can't be weaned from biventricular support**
  - **Pt must be under clinical study**

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Notes/Comments/Questions

Revision of artificial heart procedure code

- 37.52 Implantation of internal biventricular heart replacement system
  - Includes artificial heart
- New code 37.55 Removal of internal biventricular heart replacement system
  - Removal prior to cardiac transplant
- Removed 37.52 from non coverage list, put on limited coverage edit
  - DX V70.7 Exam of participant in clinical trial Must be included or claim will be denied
  - Retroactive to May 1, 2008

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Revision of artificial heart procedure code *(cont.)*

- Assigned to MS-DRG 001 Heart Transplant or implant of Heart Assist System with Major Comorbidity or Complication (MCC)
- MS-DRG 002 Heart Transplant or Implant of Heart Assist System without Major Comorbidity or Complication (MCC)

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Transferred Stroke Patients with tPA

- Tissue Plasminogen Activator
- Procedure code 99.10, Injection/infusion thrombolytic agent
- Used for blood clots, not active bleeding/hemorrhagic stroke
- Best if used in first three hours of onset in embolic stroke
- CMS DRG 559: DRG higher weight recognized the need for better overall care of patients
  - MS-DRG 061-063 (with tPA)
  - MS-DRG 064-066 (No tPA) Lower weighted

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Problem: When was tPA Given?

- Many tx in ED before transfer to stroke center (another hospital)
- Receiving facility loses additional reimbursement but still have increased healthcare needs
- New V code V45.88 Status post admin of tPA in different facility within 24 hours prior to admission to current facility
- Not enough data yet to change MS-DRG rates, but this will allow study

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Intractable Epilepsy with Video EEG

- vEEG Video Electroencephalogram
- Pt with seizures admitted for 4-6 days for comprehensive eval
  - ID seizure type, cause and location of seizure
  - 24 hour monitoring
- MS-DRGs 100 Seizure with MCC, 101 Seizures without MCC
- Epilepsy codes 345.0x-345.9x
  - 5th digits to show without mention of intractable epilepsy (0)
  - With intractable epilepsy (1)

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Intractable Epilepsy with Video EEG
(cont.)

- Request by National Association of Epilepsy to subdivide MS-DRG 101 because of increased costs
- Final Rule: Not enough evidence to support this, so no changes made
- No changes can be made until further MS-DRG system claims data becomes available

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MDC 5 Diseases and Disorders of Circulatory System

- AICD Lead and Generator Procedures
  - Automatic Implantable Cardioverter-Defibrillators
- New MS-DRG 265 separately identifies different procedures performed
- MS-DRG 245 AICD Generator Procedures
  - Includes codes 37.96, 37.98, 00.54 (pulse generator only)
- MS-DRG 265 AICD Lead Procedures
  - Procedure codes 37.95, 37.97, 00.52 (leads)
- Effective Oct. 1, 2009

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Left Atrial Appendage Device

- Atrial Fibrillation (AF) primary cardiac abnormality association with ischemic and embolic stroke
- Most ischemic strokes with AF due to embolism or thrombus formed in left atrial appendage
- Use of anticoagulants problematic for older pts.

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Notes/Comments/Questions

Left Atrial Appendage Device (cont.)

- Chronic Warfarin INR requires frequent blood tests, aspirin still questionable
- Code 37.90 Insertion of left atrial appendage device created 2004, non OR procedure, question on placement in MS-DRG System
- Data did not support movement of code or new subdivision to support

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Title Changes for 250 and 251

- Removed reference to AMI
- MS-DRG 250 Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC
- MS-DRG 251 Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC

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Notes/Comments/Questions

MDC 8 Hip and Knee Replacements and Revisions

- Request from American Association of Hip and Knee Surgeons (specialty group within AAOS)
- Want to differ between primary and revision total joint arthroplasty (TJA) procedures, impact of infections and other issues related to these procedures
- No changes made to the MS-DRGs
- Will discuss need for better information regarding codes 80.05 and 80.06 to indicate that a code for removal of joint prosthesis should not be coded if new prosthesis is inserted.
  - 80.05 Arthrotomy for removal of hip prosthesis
  - 80.06 Arthrotomy for removal of knee prosthesis

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MDC 18 Severe Sepsis

- Revising Titles to include severe sepsis
- 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
- No changes to MS-DRG 853 Infectious and Parasitic Diseases with OR Procedure with MCC

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Endotoxemia

- CME received a request to consider Endotoxemia as an MCC to be consistent with the current MS-DRG system's designation of sepsis and septicemia as MCCs
- CMS noted since a code for Endotoxemia doesn't exist in ICD-9-CM consideration cannot be given as to a severity level assignment such as MCC

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MDC 24 Multiple Significant Trauma

- MS-DRGs 963, 964, and 965 now include:
  - 958.90 (Compartment syndrome, unspecified)
  - 958.91 (Traumatic compartment syndrome of upper extremity)
  - 958.92 (Traumatic compartment syndrome of lower extremity)
  - 958.93 (Traumatic compartment syndrome of abdomen)
  - 958.99 (Traumatic compartment syndrome of other sites)

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Medicare Code Editor Changes

- V62.84 Suicidal Ideation
  - Now is acceptable as principal dx
  - Modified V code table in Official Coding Guidelines to allow use as either principal or secondary dx
  - Removed from list of unacceptable principal dx

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Males Only Edit

- The following codes have been added to the MCE edit of diagnoses allowed for males only:
  - 603.0 Encysted hydrocele
  - 603.0 Infected hydrocele
  - 603.8 Other specified types of hydrocele
  - 603.9 Hydrocele, unspecified

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Notes/Comments/Questions

Limited Coverage Edit

As previously discussed, moved 37.52, implantation of internal biventricular heart replacement system from non-covered edit to limited coverage edit with V70.7 Examination of participant in clinical trial. Retroactive to May 1, 2008

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Surgical Hierarchy

- MDC 5 Diseases and Disorders of the Circulatory System
- Reordering MS-DRG 245 (AICD Generator Procedures)
- Above MS-DRG 265 (AICD Lead Procedures)

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Notes/Comments/Questions

CC Exclusions, MCC and CC Lists

The following Tables are available to download on the CMS Web site at:

http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp?listpage=1

- Table 6G Additions to the CC Exclusions List
- Table 6H Deletions from the CC Exclusions List
- Table 6I MCC List
- Table 6J CC List

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Hospitals with High Percentage of ESRD Discharges

- Existing regulation 10% or more of total Medicare Discharges
- Hospitals receive additional payment for ESRD patients who receive dialysis treatment during a hospital stay
- Excluded patients in MS-DRGs:
  - 652 Kidney Transplant
  - 682 Renal Failure with MCC
  - 683 Renal Failure with CC
  - 684 Renal Failure without CC/MCC
  - 685 Admit for Renal Dialysis

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Add-On Payments

- For new medical service or new technology, first 2-3 years after FDA approval
- CMS has Council on Technology and Innovation (CTI) oversees this effort
- 4 applications for new technology add-on payments received
- Three did not receive final FDA approval prior to final rule, not eligible for consideration:
  - Emphasys Medical Zephyr Endobronchial Valve©
  - Oxiplex©
  - TherOx Downstream System©

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CardioWest TAH-t

- Temporary Total Artificial Heart System
  - Bridge to heart transplant device
  - Transplant eligible
  - End-stage biventricular failure
  - Can pump up to 9.5 liters blood/minute
  - Used on inpatients
- Delayed "newness" criteria because not covered until now
- Approving additional payment under add-on criteria
- Triggered by Code 37.52 Implantation of total heart replacement system, Condition code 30, and diagnosis code V70.7 Examination of participant in clinical trial
- Max Additional Payment of $53,000

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Post-Acute Transfer Policy

- **FY 2007, 190 DRGs subject to policy**
- **FY 2008, 273 of 745 DRGs subject to policy (see Table 5 of Final Rule)**
  - **If one DRG meets criteria, all severity levels of that DRG are subject to policy**
- **FY 2009, Proposed Change to transfer to HH policy: extend the 3-day window to 7 days**
  - **If HH not related to IP admission, condition code 42; if related but starts > 7 days after discharge, use condition code 43**
  - **Either of these condition codes with discharge code 06 would result in full payment**

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Post-Acute Transfer Policy

- **MedPAC conducted a separate review of 2005 – 2006 data which does not support expansion of window to 7 days**
- **CMS is not going to expand the window at this time, but will continue to study the data**

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Steps to Improving Quality of Care

- **CMS implemented Quality Measures**
- **Public Reporting of Provider & Plan Performance**
- **Linking payment incentives to reporting of Quality Measures**
- **Plans to link payment to Performance on Quality Measures**

  Called *Value-Based Purchasing*

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Quality Measures for FY 2008

- **6 additional measures (27 total)**
- **HCAHPS Survey (patient satisfaction data)**
- **VTE prophylaxis ordered for surgery patients**
- **VTE prophylaxis within 24 hrs pre/post surgery**
- **Prophylactic antibiotic for surgical patients**
- **Heart Failure & AMI 30-day mortality (based on claims data)**

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Quality Measures for FY 2009

- **4 measures for FY 2009 already approved in FY 2008 rule**
- **7 measures approved for OP reimbursement in CY 2008 rule**

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Quality Measures for FY 2009

- **30-day mortality Pneumonia (claims data)**
- **Cardiac surgery patients w/controlled 6 am postop serum glucose**
- **Surgery patients w/appropriate hair removal**
- **Total measures for FY 2009 is *30***

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Notes/Comments/Questions

Quality Measures for FY 2010

- SCIP measure: CVS patients on beta blocker prior to arrival who received one during perioperative period
- 4 nursing measures proposed: 1) failure to rescue, 2) pressure ulcer prevalence & incidence by severity, 3) patient falls prevention, 4) patient falls w/injury
  - Only #1 approved, the other 3 will be included in FY 2011 proposed rule

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Quality Measures for FY 2010

- 3 readmission measures proposed: 30-day readmission for AMI, heart failure, pneumonia (claims data)
  - Heart Failure readmission rate approved
- AMI & Pneumonia to be finalized in the CY 2009 OPPS Final Rule contingent on NQF endorsement

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Quality Measures for FY 2010

- **6 VTE measures proposed, not approved**
- **5 Stroke measures proposed, not approved**
- **9 AHRQ Patient Safety (PSI) & Inpatient Quality Indicators (IQI) measures**
  - **claims-based outcome measures; proposed submission of all-payer claims data – to be calculated on Medicare claims**

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Quality Measures for FY 2010

- **Adopting AHRQ IQI AAA mortality measure – stroke mortality measure to be included in a future rule**
- **15 Cardiac Surgery measures proposed: to accept data from Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry**
  - **Only 1 approved: Participation in Systemic Database for Cardiac Surgery**

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Notes/Comments/Questions

Approved Quality Measures

- FY 2009 – 30 measures
- FY 2010 – 43 measures, retire 1 measure= 42 total measures
- FY 2011 – table of 59 measures and 4 measure sets from which to select future quality measures for RHQDAPU program

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Goals of RHQDAPU Program

- Include increased outcome, efficiency & experience of care measures
- Expand scope of services to which measures apply
- Consider burden of collecting data
- Harmonize measures w/other quality programs
- Seek alternative sources of data
- Weigh meaningfulness & use of data compared to burden of submitting it

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Uses of POA Indicator

- Analysis of Factors to prevent HACs
- Calculate incidence of HACs by hospital
- Monitoring Complication Rates
- Setting Benchmarks for Performance
- Risk Adjustment for Quality Reporting
- Public Reporting of POA data

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Polling Question #1

Has your facility been monitoring the number of Hospital-acquired conditions (HACs) being submitted on your claims?

*1 Yes

*2 No

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Use of POA for Quality Reporting

- Estimates vary about the impact of POA indicators in assessing quality
- One Canadian study on CABG patients estimates that 13-35% of identified complications were POA
- POA has high impact on public measures, including:
  - AHRQ PS Indicators
  - HAC measures
  - VBP program
  - SCIP measures

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Purpose of POA Indicators

- For hospital-acquired conditions that have been approved as part of the Value-Based Purchasing Program, if that condition is only MCC/CC on the claim, it will be paid at the lower-weighted DRG
- Pt admitted and develops decubitus during stay, which has "N" POA indicator
- Payment would be based on the DRG as if the decubitus was not present

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Notes/Comments/Questions

Impact on Reimbursement – FY09

- Patient admitted w/Pneumonia due to Candidiasis
- Secondary Dx: Decubitus ulcer Stage III (MCC), COPD, CHF, A fib, Anemia
- MS-DRG 177 Resp Inf w/MCC r.w. 2.0391 $11,215
- Decubitus not POA, case regrouped to MS-DRG 179 Resp inf w/o MCC/CC r.w. 1.0409 $5,725
- $5,490 difference + average cost to tx decubitus of $43,180

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Who is Exempt?

- CA Hospitals
- Maryland Waiver Hospitals
- LTAC Hospitals
- Cancer Hospitals
- Children's Hospitals
- IRF
- IPF

NOTE: Some states have expanded to other facilities, such as rehab, or to certain OP Encounters.

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POA Indicators

- Y = Yes (POA)
- N = No (POA)
- U = Unknown (documentation insufficient to determine if condition POA); use of this indicator will be monitored; query the provider
- W = clinically undetermined (provider unable to clinically determine if condition was POA), e.g. complex sepsis case
- 1 = Exempt from POA reporting

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Value-Based Purchasing (P4P)

- Reimbursement based on Quality of Care (Quality Measures & Hospital-Acquired Conditions)
- Proposed Rule indicates potential application to OP Depts, SNFs, ESRD facilities & MD practices
- Proposed modification of Medicare secondary payer policy: provider that failed to prevent a HAC would pay for all or part of necessary follow up care in a second setting
- Payers starting to refuse payment for NQF's "never" events

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Hospital-Acquired Conditions (HACs)

- 98,000 Americans die each year due to medical errors – costs are $17-$29 billion
- In 2000, CDC estimated hospital-acquired infections added nearly $5 billion to US healthcare costs
- A 2007 study indicated 1.7 million hospital – acquired infections in 2002, 99,000 deaths
- 2007 Leapfrog Group survey of 1,256 hospitals: 87% do not follow prevention guidelines for most common infections

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Evidence-Based Guidelines

- ***Surgical Site Infections***: prophylactic antibiotic, using clippers rather than razors, tight control of postop glucose
- ***Delirium***: reducing certain meds, reorienting patient, assuring sensory input & sleep, avoid malnutrition & dehydration
- ***VAP***: educating staff, hand washing, gowns & gloves, proper patient positioning, elevating head of bed, changing vent tubing, sterilizing reusable equipment, monitor sedation daily, etc.

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Notes/Comments/Questions

Hospital-Acquired Conditions (HACs) – effective 10/1/08

- Catheter-associated UTI 996.64 (CC) ($44,043/stay)
- Pressure (decubitus) ulcers (Stage 3 or 4) 707.23, 707.24**(MCCs) ($43,180/stay)
- Object left in during surgery 998.4,998.7 (CCs) ($63,631/stay)*
- Air embolism 999.1 (MCC) ($71,636/stay)

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Hospital-Acquired Conditions (HACs) – effective 10/1/08 (cont.)

- Blood incompatibility 999.6 (CC) ($50,455/stay)
- Vascular catheter-associated infections 999.31 (CC) ($103,027/stay)
- Mediastinitis following CABG 519.2 (MCC) + 36.10-36.19 ($299,237/stay)
- Falls, fractures, dislocations, intracranial injuries, crushing injury, burns, electric shock ($33,894/stay)

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Final Rule for FY 2009 – HACs effective 10/1/08

- **Poor Glycemic Control: Diabetic Ketoacidosis (250.10 – 250.13, MCC); Nonketotic Hyperosmolar Coma (250.20 – 250.23, MCC); Hypoglycemic Coma (251.0, CC); Secondary DM w/Ketoacidosis (249.10 or 249.11, MCC); Secondary DM w/Hyperosmolarity (249.20 or 249.21, MCC) ($35,000 - $45,000/stay)**
- **Surgical Site Infections:**
  - **Infection orthop device (996.67, CC) or Other postop infection (998.59, CC) + Procedures on Shoulder (81.23, 81.83), Elbow (81.24, 81.85) & Spine (81.01 – 81.08, 81.31 – 81.38) ($148,172/stay)**
  - **Pdx of Morbid Obesity (278.01) AND 998.59 + Lap Gastric Bypass (44.38), Gastroenterostomy (44.39), Lap Gastric Restrictive Procedure (44.95) ($233,614/stay)**

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Final Rule for FY 2009 – HACs effective 10/1/08 *(cont.)*

- **DVT (453.40 – 453.42, CC) or *PE* (415.11, 415.19, MCC) + Total Knee (81.54) OR Hip Replacement (00.85-00.87, 81.51-81.52, or 81.54) ($58,625/stay)**

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Notes/Comments/Questions

Resource/Reference List

- **Federal Register, August 19, 2008, CMS FY09 IPPS Rules and Regulations**
  http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf
- **CMS Acute Inpatient Files for Download**
  http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp?listpage=1
- **POA Reporting Guidelines**
  http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf

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Appendix

Resource / Reference List

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http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp?listpage=1

http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf

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