FY 2009 Hospital IPPS Final Rule

by Linda Schwab, RHIT

The final rule for the FY 2009 hospital inpatient prospective payment system (IPPS) went into effect October 1, 2008. Although there are relatively few changes to MS-DRGs and the complication and comorbidity (CC) and major CC (MCC) lists, the final rule signals that the Centers for Medicare and Medicaid Services (CMS) is moving forward with its pay-for-performance efforts.

Changes such as the adoption of MS-DRGs, refinement of CCs and MCCs, hospital-acquired conditions, present on admission indicators, and quality measures all indicate that hospitals must work harder than ever to improve quality of care, documentation, and coding practices.

Changes to MS-DRGs

Following the major transition from CMS-DRGs to MS-DRGs in FY 2008, hospitals are experiencing only a few adjustments in FY 2009.

Pre-MDC, Artificial Heart Devices

New limited coverage is available for qualified inpatients participating in clinical trials. Claims will receive the "Limited Coverage" edit rather than the prior "Non-Covered Procedure" edit if they include both the diagnosis code V70.7, Examination of participant in clinical trial, and procedure code 37.52, newly titled Implantation of total internal biventricular heart replacement system.

A new technology add-on payment is approved for these cases as well. To qualify for a maximum add-on payment of $53,000, claims must include diagnosis code V70.7, procedure code 37.52, and condition code 30, Qualifying clinical trial. Procedure code 37.52 has been moved from MS-DRG 215, Other Heart Assist System Implant, to MS-DRG 001, Heart Transplant or Implant of Heart Assist System w/MCC, and MS-DRG 002, Heart Transplant or Implant of Heart Assist System w/o MCC.

MDC 5, Diseases and Disorders of the Circulatory System

CMS recognizes that automatic implantable cardioverter-defribrillator (AICD) generator insertions incur a significantly higher cost than AICD-lead insertions. Therefore, MS-DRG 245, Automatic Implantable Cardioverter-Defibrillator Lead and Generator Procedures, is now subdivided into MS-DRG 245 and MS-DRG 265.

MS-DRG 245, AICD Generator Procedures, includes procedure codes 37.96, 37.98, and 00.54. MS-DRG 265, AICD Lead Procedures, includes procedure codes 37.95, 37.97, and 00.52.

Revisions to MS-DRG Titles

For MS-DRGs 870, 871, and 872, the words "or severe sepsis" were added to their descriptions:

- 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

The addition of "severe sepsis" was applauded by several commenters, noting that the change would assist in identification of severe sepsis and lead to improved quality outcomes.

MS-DRGs 154, 155, and 156 were changed to reflect that they include nontraumatic as well as traumatic diagnoses. They now read:

- MS-DRG 154, Other Ear, Nose, Mouth and Throat Diagnoses with MCC
- MS-DRG 155, Other Ear, Nose, Mouth and Throat Diagnoses with CC
- MS-DRG 156, Other Ear, Nose, Mouth and Throat Diagnoses without CC/MCC

MS-DRGs 250 and 251 were revised by deleting the words "or MI" from their titles. They now read:

- MS-DRG 250, Percutaneous Cardiovascular Procedure without Coronary Artery Stent with MCC
- MS-DRG 251, Percutaneous Cardiovascular Procedure without Coronary Artery Stent without MCC

MS-DRG 864 was revised following the addition of new ICD-9-CM diagnosis codes for various types of fever, effective October 1, 2008. Previously titled "Fever of Unknown Origin," it is now titled simply "Fever."

Changes to MCCs and CCs

Additions and deletions to the MCC and CC lists were the result of changes to ICD-9 codes for FY 2009. The complete summaries of additions and deletions to MCCs and CCs are found in tables 6I.1, 6I.2, 6J.1, and 6J.2 in the final rule.

Changes to the MCC list include the addition of the new methicillin resistant staphylococcus aureus (MRSA) codes for septicemia and pneumonia (038.12 and 482.42), secondary diabetes mellitus codes (249.10–249.31), and pressure ulcer stages III and IV codes (707.23 and 707.24).

Additions to the CC list include the new codes for relapse of leukemia. New codes for malignant carcinoid tumors, malignant pleural effusion (511.81), and ventilator associated pneumonia (997.31) appear on the CC list as well.

Pressure ulcer codes specific to the back, hip, buttock, ankle, and heel (707.02–707.07) have been deleted from the MCC list. The pressure ulcer codes for unspecified site, elbow, and other site have been deleted from the CC list.

Hospital-Acquired Conditions

In accordance with requirements of the Deficit Reduction Act of 2005, CMS selected certain hospital-acquired conditions (HACs) that will not be paid as CCs or MCCs if they are not present on admission (POA). This change in payment structure is effective with discharges on October 1, 2008. In addition to the eight conditions approved in FY 2008, CMS added three new HACs in the FY 2009 final rule, for a total of 11 HACs.

For a list of the HACs from fiscal year 2008 and 2009, see the table below.

Close attention must be paid to assignment of the correct POA indicators in order to reflect quality of care and receive accurate reimbursement. Hospitals should work closely with all caregivers to provide proper documentation of HACs, POA, and all patient conditions.

POA Indicators

The FY 2009 rule approved two POA indicators that, when assigned to a selected HAC, are no longer paid as a CC or MCC. The two POA indicators are N, not present on admission, and U, insufficient documentation to support that the condition was present on admission.

In the final rule, CMS also stressed the importance of accurate coding of all diagnoses and POA indicators, regardless of the impact on payment. It refers to AHIMA's Standards of Ethical Coding that require accurate coding consistent with medical record documentation no matter what the implication is for payment.

Documentation and Coding Adjustment

As outlined in the FY 2008 rule, a documentation and coding adjustment of -0.9 percent will be applied to base rates during FY 2009. The adjustment is cumulative over a three-year period. Therefore, the -0.6 percent adjustment from FY 2008 is added to the -0.9 percent for FY 2009, resulting in a combined total adjustment rate of -1.5 percent for FY 2009.

The intention of the documentation and coding adjustment is to maintain budget neutrality as hospitals gear up to code and document in more detail due to the MS-DRG requirements. CMS assumes that improved documentation and coding will lead to an increased case-mix index that does not truly represent a change in patient population. Therefore, the statute requires that the adjustment be applied to hospital base rates over a three-year period to offset the expected increased case-mix. The phase-in is scheduled as follows:

- FY 2008 = -0.6 percent
- FY 2009 = -0.9 percent
- FY 2010 = -1.8 percent

Expansion of Quality Measures for FY 2010

Although the final rule did not include approval of all 72 quality measures that were proposed for FY 2010 payment determination, the expansion of quality measures that hospitals must report is still significant. One of the current 30 measures was retired and an additional 13 measures were approved, resulting in a total of 42 measures approved for payment determination in FY 2010. The complete list of quality measures is available in table "Reporting Hospital Quality Data for Annual Payment Update" on pages 48609–10 of the final rule.

Number of Diagnoses and Procedures Included in Claims Processing

CMS explained that although it is currently capable of receiving up to 25 diagnosis codes and 25 procedure codes in the HIPAA 837i format, it is unable to process more than the first nine diagnoses and first six procedures for payment calculation. HIPAA does not require that it process more than nine diagnosis and six procedure codes.

In response to several commenters, CMS agreed that processing additional diagnosis and procedure codes would add value by obtaining additional data to reflect patients' severity of illness. However, at this time CMS's electronic systems are unable to accommodate such a change. It will continue to evaluate expansion of its system to allow processing of more codes.

No Change to Postacute Care Transfer Policy for Home Health

Although a change from a three-day window to a seven-day window following inpatient discharge was proposed for home health services, CMS did not approve the measure in the final rule. The proposal would have required that claims for patients receiving home health services within seven days following discharge be subject to reduced payment according to the Postacute Care Transfer Policy.

CMS received many comments in opposition to the proposed change and decided not to finalize the change. It will continue to monitor the current policy of three days and may make adjustments at a later time.

11 Hospital-Acquired Conditions in FY 2009 Rule

In the FY 2008 final rule, CMS identified eight hospital-acquired conditions (HACs) that will not be paid as CCs or MCCs if they are not present on admission. The FY 2009 final rule adds three new HACs. All are effective with discharges beginning October 1, 2008.

HAC	**CC/MCC (ICD-9-CM Codes)**
FY 2008 HACs, Effective October 1, 2008	

Foreign object retained after surgery	998.4, 998.7
Air embolism	999.1
Blood incompatibility	999.6
Pressure ulcers, stages III & IV	707.23, 707.24
Falls and trauma Fractures Dislocations Intracranial injuries Crushing injuries Burns Electric shock	 800–829 830–839 850–854 925–929 940–949 991–994
Catheter-associated urinary tract infections	996.64, 112.2, 590.10–590.81, 595.0, 597.0, 599.0
Surgical site infection, mediastinitis, following CABG	519.2 and one of the following procedure codes: 36.10 or 36.19
Vascular catheter-associated infection	999.31
FY 2009 Additional HACs, Effective October 1, 2008	
Manifestations of poor glycemic control	250.10–250.13, 250.20–250.23, 251.0, 249.10–249.11, 249.20–249.21
Surgical site infection following: Certain orthopedic procedures Bariatric surgery for obesity	996.67 or 998.59 and one of the following procedure codes: 81.01–08, 81.23, 81.24, 81.31–38, 81.83, or 81.85 278.01 (principal diagnosis), 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures	415.11, 415.19, 453.40–453.42 and one of the following procedure codes: 00.85, 00.86, 00.87, 81.51, 81.52, or 81.54

Reference

Centers for Medicare and Medicaid Services. “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates.” *Federal Register* 73, no. 161 (Aug. 19, 2008). Available online at www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf.

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Article citation:
Schwab, Linda. "FY 2009 Hospital IPPS Final Rule" *Journal of AHIMA* 79, no.11 (November 2008): 86-88.