FY 2010 Changes to the Hospital IPPS

By Kathy DeVault, RHIA, CCS

The final rule for the FY 2010 Hospital Inpatient Prospective Payment System was released on July 31, 2009. Changes in the rule went into effect with inpatient discharges of October 1, 2009, and are reflected in Grouper Version 27.0.

The changes to MS-DRGs and the complication and comorbidity (CC) and major complication and comorbidity (MCC) lists are relatively small, but the Centers for Medicare and Medicaid Services (CMS) continue to move its pay-for-performance efforts forward.

FY 2010 MS-DRG Documentation and Coding Adjustment

In the proposed rule, CMS sought public comment on the proposed -1.9 percent prospective adjustment to the standardized amounts under section 1886(d) of the Social Security Act to address the effects of documentation and coding changes unrelated to changes in real case-mix in FY 2008. After considering the public comments, CMS postponed adopting documentation and coding adjustments until a full analysis of case-mix changes can be completed.

This represents an increase of $2.2 billion in payments to hospitals in FY 2010.

Preventable Hospital-Acquired Conditions, including Infections

For FY 2010 CMS has chosen not to change the Hospital-Acquired Conditions list. Instead, it will evaluate the program to ensure a clear understanding of its impact. This will aid decision making when determining next steps in the program.

Two new diagnosis codes have been added for arm fractures for falls and trauma to reflect coding updates for fractures. They include:

- 813.46, Torus fracture of ulna alone
- 813.47, Torus fracture of radius and ulna

Changes to MS-DRGs

CMS recognized that infected hip and knee replacement cases are significantly more expensive to treat than those in their current MS-DRG assignment. Therefore, reassigning this MS-DRG to MDC 8, Diseases and Disorders of the Musculoskeletal System and Connective Tissue: Infected Hip and Knee Replacements, will more accurately reflect the costs associated with treating the removal of hip and knee prostheses.

Procedure codes 80.05 and 80.06 will be moved to MS-DRGs 463, 464, and 465. The code title of procedure code 80.05 was revised to read “Arthrotomy for removal of prosthesis without replacement, hip,” while the code title of procedure code 80.06 was revised to read “Arthrotomy for removal of prosthesis without replacement, knee.”

CC/MCC Additions

Additions to the CC list for FY 2010 include:

- 209.71–209.74, Secondary neuroendocrine tumors
- 416.2, Chronic pulmonary embolism
- 453.50–453.89, Chronic venous embolism and thrombosis and acute venous embolism and thrombosis
- 569.71–569.79, Pouchitis and other complications of intestinal pouch

- 670.10–670.30 (except 670.22, 670.24), Puerperal endometritis, puerperal sepsis, and puerperal septic thrombophlebitis
- 768.70–768.72, Hypoxic-ischemic encephalopathy
- 813.46–813.47, Torus fracture of ulna and torus fracture of radius and ulna

Additions to the MCC list for FY 2010 include:

- 277.88, Tumor lysis syndrome
- 670.22–670.84 (except 670.30), Puerperal endometritis, puerperal sepsis, and puerperal septic thrombophlebitis
- 756.72–756.73, Omphalocele and gastroschisis
- 768.73, Severe hypoxic-ischemic encephalopathy
- 779.32, Bilious vomiting in newborn

The complete, updated MCC, CC, and non-CC exclusions lists are available on the CMS Web site at www.cms.hhs.gov/AcuteInpatientPPS.

Medicare Code Editor Edits

Wrong Procedure Performed Edit

Three E codes will be included in the "Wrong Procedure Performed" edit, one with a revised title and two new E codes. They include:

- E876.5, Performance of wrong operation (procedure) on correct patient
- E876.6, Performance of operation (procedure) on patient not scheduled for surgery
- E876.7, Performance of correct operation (procedure) on wrong side/body part

The ICD-9-CM Official Guidelines for Coding and Reporting were updated effective October 1, 2009, to recognize the fact that CMS requires the reporting of E codes as part of its wrong procedure performed national coverage decision.

The Medicare Code Editor (MCE) will be changed so that E codes E876.5–E876.7 will trigger the "Wrong Procedure Performed" edit whether they are in the principal or secondary diagnosis position. Any claim with this edit will be rejected.

Cases with an omission of these E codes may be subject to retrospective review by the Recovery Audit Contractor (RAC) and then subsequently denied.

Diagnoses Allowed for Males Only Edit

There are four diagnoses that were inadvertently left off of the MCE titled "Diagnoses Allowed for Males Only" in FY 2009. These include:

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

These four diagnosis codes will be added to the MCE for FY 2010.

Manifestation Codes as Principal Diagnosis Edit

The National Center for Health Statistics has removed the advice "code first associated disorder" from three codes, thereby making them acceptable principal diagnosis codes. They are:

- 365.41, Glaucoma associated with chamber angle anomalies
- 365.42, Glaucoma associated with anomalies of iris
- 365.43, Glaucoma associated with other anterior segment anomalies

Unacceptable Principal Diagnosis Edit

For FY 2010, codes 209.00–209.69, Neuroendocrine tumors, were removed from the MCE for unacceptable principal diagnosis. An instructional note under this subcategory, "Code first any associated multiple endocrine neoplasia syndrome (258.01–258.03)," was misinterpreted as the codes in subcategory 209 were unacceptable principal diagnoses.

Procedures Allowed for Females Only Edit

Two procedure codes were inadvertently left off the MCE titled "Diagnoses Allowed for Females Only" in FY 2009. They include:

- 75.37, Amnioinfusion
- 75.38, Fetal pulse oximetry

These two procedure codes will be added to the MCE for FY 2010.

New Technology

The CardioWest Temporary Total Artificial Heart System was approved as a new technology for FY 2009 add-on payments to be continued in FY 2010, though its use is limited to approved clinical trial settings. An add-on payment is triggered by ICD-9-CM code 37.52, Implantation of total heart replacement system, condition code 30, and the diagnosis code reflecting clinical trial, V70.7. The maximum add-on payment for the system is $53,000.

Spiration IBV Valve System was also approved as a new technology for add-on payments in FY 2010. The add-on payment is limited to cases involving prolonged air leaks following lobectomy, segmentectomy, and lung volume reduction surgery. An add-on payment is triggered by ICD-9-CM code 33.71, Endoscopic insertion or replacement of bronchial valve(s), or 33.73, Endoscopic insertion or replacement of bronchial valve(s), multiple lobes, in combination with procedure code 32.22, 32.30, 32.39, 32.41, or 32.49. Eligible cases will be identified by MS-DRGs 163, 164, and 165. The maximum add-on payment is $3,437.50.

Hospital Quality Reporting

To receive a full payment in FY 2010 hospitals must continue to publicly report data on 28 measures that are required for FY 2009. Fifteen additional measures have been added for FY 2010.

The hospital quality reporting measures are delineated as follows:

- 26 chart-abstracted process measures, which measure care provided for acute myocardial infarction, heart failure, pneumonia, or surgical care improvement (SCIP)
- Six claims-based measures, which evaluate 30-day mortality or 30-day readmission rates for acute myocardial infarction, heart failure, or pneumonia
- Nine Agency for Healthcare Research and Quality claims-based patient safety or inpatient quality indicator measures
- One claims-based nursing sensitive measure
- One structural measure that assesses participation in a systematic database for cardiac surgery
- The Hospital Consumer Assessment of Healthcare Providers and Systems patient experience of care survey

Two measures have been retired for FY 2010:

- Oxygenation assessment for pneumonia care
- Beta blocker on arrival for heart attack care

The discussion regarding hospital quality measures can be found beginning on page 43860 of the *Federal Register*.

For FY 2011, CMS has finalized two new chart-abstracted surgical care measures and two new structural measures, as well as eliminating a duplicative measure. These new measures include:

- Postoperative urinary catheter removal on postoperative day one or two
- Perioperative temperature management
- Participation in a systematic clinical database registry for stroke care
- Participation in a systematic clinical database registry for nursing sensitive care

The complete list of the 46 measures can be found on pages 43872–75 of the *Federal Register*.

Reference

Centers for Medicare and Medicaid Services. "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2010 Rates." *Federal Register 74,* no. 165 (Aug. 27, 2009). Available online at http://edocket.access.gpo.gov/2009/E9-18663.htm.

Kathy DeVault (kathryn.devault@ahima.org) is a manager of practice resources at AHIMA.

Article citation:
DeVault, Kathryn. "FY 2010 Changes to the Hospital IPPS" *Journal of AHIMA* 80, no.11 (November 2009): 70-72.