FY 2011 Changes to the Hospital IPPS

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The final rule for the FY 2011 Hospital Inpatient Prospective Payment System was released July 30, 2010. Changes in the rule went into effect with October 1, 2010, inpatient discharges.

The changes to MS-DRGs and the complication and comorbidity (CC) and major complication and comorbidity (MCC) lists are relatively small for FY 2011, but several are significant.

MS-DRG Documentation and Coding Adjustment

The Centers for Medicare and Medicaid Services (CMS) finalized its proposed -2.9 percent documentation and coding adjustment to eliminate what CMS claims is the effect of coding or classification changes that do not reflect real changes in case mix. Due to this adjustment and other policy changes, hospitals will see their FY 2011 payments decrease by 0.4 percent on average compared to FY 2010. In total, the adjustment cuts $3.7 billion in Medicare hospital inpatient payments.

Although a formal proposal has not been made, CMS anticipates removing the -2.9 percent adjustment from the rates in FY 2012, when it would also be necessary to apply the remaining -2.9 percent adjustment. These two steps would effectively cancel each other out, resulting in an aggregate adjustment of approximately 0 percent in FY 2012.

MS-DRG Reclassifications

Diagnosis code 251.3, Postsurgical hypoinsulinemia, was added to MS-DRG 008, Simultaneous Pancreas/Kidney Transplant. As a conforming change, diagnosis code 251.3 was also added to the list of principal or secondary diagnosis codes assigned to MS-DRG 010, Pancreas Transplant.

MS-DRG 009, Bone Marrow Transplant, was deleted. New MS-DRGs 014, Allogeneic Bone Marrow Transplant (including procedure codes 41.02, 41.03, 41.05, 41.06, and 41.08), and 015, Autologous Bone Marrow Transplant (including procedure codes 41.00, 41.01, 41.04, 41.07, and 41.09), were added. There are cost differences associated with allogeneic and autologous bone marrow transplants that warrant separate MS-DRGs for these procedures.

CMS received a request to analyze diagnosis code V45.88, Status post-administration of tissue plasminogen activator (rtPA) in a different facility within the last 24 hours prior to admission to current facility, under MDC 1, Disease and Disorders of the Nervous System. It made no changes to MS-DRGs 061, 062, 063, 064, 065, and 066 or the assignment of diagnosis code V45.88.

CMS made no changes to MS-DRGs 233, 234, 235, or 236 for cases reporting procedure code 88.59 for intraoperative fluorescence vascular angiography and x-ray coronary angiography in coronary artery bypass graft surgery.

For MDC 6, Diseases and Disorders of the Digestive System: Gastrointestinal Stenting, CMS made no MS-DRG modifications to cases involving the use of gastrointestinal stents.

For MDC 8, Diseases and Disorders of the Musculoskeletal System and Connective Tissue: Pedicle-Based Dynamic Stabilization, CMS concluded that the insertion of a Dynesys Dynamic Stabilization System is clinically not a lumbar fusion and finalized its proposal not to reassign cases reporting procedure code 84.82 from MS-DRG 490 to MS-DRG 460.

For MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period, newborn cases assigned to MS-DRGs 790–795 and identified with discharge status 05, Discharged/transferred to a designated cancer center or children's hospital, will be reassigned to MS-DRG 789, Neonates, Died or Transferred to Another Acute Care Facility. Code V64.05,

Vaccination not carried out because of caregiver refusal, was removed from MS-DRG 794 (Neonate with Other Significant Problems) and added to the secondary diagnosis list for MS-DRG 795 (Normal Newborn).

Medicare Code Editor Changes

There was a proposal to add code 536.3, Gastroparesis, to the unacceptable principal diagnosis edit list. Code 536.3 has a "code first underlying disease" note. CMS withdrew this proposal for FY 2011, otherwise gastroparesis could not be assigned as a principal diagnosis.

The entire open biopsy check edit was deleted, including the 63 codes included in the edit. At this time, the edit no longer serves a useful purpose. In the current MS-DRGs, the open biopsy codes do not have as significant an impact as they did in the earlier versions of the DRGs.

To conform to the changes to pre-MDC MS-DRGs 008 and 010, CMS added diagnosis code 251.3 to the list of acceptable principal or secondary diagnosis codes for a noncovered procedure edit. CMS added diagnosis code 251.3, Postsurgical hypoinsulinemia, to MS-DRGs 008 and 010.

CC/MCC Additions

Additions to the CC list for FY 2011 include:

- 278.03, Obesity hypoventilation syndrome
- 488.02, Influenza due to identified avian influenza virus with other respiratory manifestations
- 488.09, Influenza due to identified avian influenza virus with other manifestations
- 584.9, Acute kidney failure, unspecified
- 999.83, Hemolytic transfusion reaction, incompatibility, unspecified
- 999.84, Acute hemolytic transfusion reaction, incompatibility unspecified
- 999.85, Delayed hemolytic transfusion reaction, incompatibility unspecified

Additions to the MCC list for FY 2011 include codes 488.01, Influenza due to identified avian influenza virus with pneumonia, and 488.11, Influenza due to identified novel H1N1 influenza viurs with pneumonia.

Code 584.9, Acute renal failure, unspecified, was reclassified from an MCC to a CC. This term is used for a wide variety of patients and identifies patients who are not consistently at the highest level of severity. CMS claims data found that diagnosis code 584.9 is more appropriately classified at the CC level.

Hospital-Acquired Conditions

CMS did not add or remove any hospital-acquired conditions (HACs); rather, it continues to focus on evaluating the impact of the HAC policy. The HAC list was modified to reflect changes to diagnosis codes and the list of CCs and MCCs. This includes replacing code 999.6, ABO incompatibility reaction, with five new codes: 999.60, 999.61, 999.62, 999.63, and 999.69.

On or after January 1, 2011, hospitals are required to report the POA indicator using the 5010 electronic transmittal standards format. The 5010 format removes the need to report the POA indicator of "1" for codes that are exempt from POA reporting. The POA field will instead be left blank.

New Technology Add-on Payments

The Spiration IBV Valve System was approved for add-on payments. CMS will continue to make add-on payments for MS-DRGs 163–165 (with procedure code 33.71 or 33.73 in combination with procedure code 32.22, 32.30, 32.39, 32.41, or 32.49). It will also make add-on payments for MS-DRGs 199–201 with the presence of diagnosis code 512.1 in combination with procedure codes 33.71 and 33.73.

The CardioWest Temporary Total Artificial Heart System was also approved for add-on payments. CMS will continue new technology add-on payments for cases involving this system with a maximum add-on payment of $53,000.

The Auto Laser Interstitial Thermal Therapy System, including procedure code 17.61 in combination with a primary diagnosis code that begins with a prefix of 191, was approved for add-on payments. It is identified by assignment to MS-DRGs 25, 26, and 27 with a maximum add-on payment of $5,300.

Hospital Quality Reporting

To receive full payment in FY 2011, hospitals must report a total of 46 quality measures. For the FY 2011 payment determination, CMS retained 41 of the FY 2010 quality measures.

Two program quality measures (death among surgical patients with treatable serious complications and failure to rescue) were combined into a single measure titled death among surgical patients with serious, treatable complications. Two chart-abstracted measures (postoperative urinary catheter removal on postoperative day 1 or 2 and perioperative temperature management) and two structural measures (participation in a systematic clinical database registry for stroke care and participation in a systematic clinical database registry for nursing sensitive care) were added.

The complete list of quality measures can be found beginning on page 517 of the August 16, 2010, *Federal Register*.

Reference

Centers for Medicare and Medicaid Services. “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2011 Rates.” *Federal Register* 75, no. 157 (Aug. 16, 2010). Available online at http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf.

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