FY 2012 Changes to the Hospital IPPS

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The final rule for the FY 2012 Hospital Inpatient Prospective Payment System was released August 1, 2011. Changes in the rule went into effect with October 1, 2011, inpatient discharges.

MS-DRG Documentation and Coding Adjustment

The Centers for Medicare and Medicaid Services (CMS) finalized its proposed documentation and coding adjustment at 2 percent. The adjustment is a decrease from CMS's initial proposal of 3.15 percent and FY 2011's 2.9 percent. It represents $1.2 billion more in hospital payments in FY 2012 than allotted in the proposed rule.

CMS finalized the documentation and coding adjustment to eliminate what it claims is the effect of coding or classification changes that do not reflect real changes in case mix. CMS will continue its current methodology of calculating the documentation and coding adjustment and assessing hospitals until it has recouped what it believes it has overpaid.

MS-DRG Reclassifications

CMS deleted MS-DRG 015, Autologous Bone Marrow Transplant, and created MS-DRG 016, Autologous Bone Marrow Transplant with CC/MCC, and MS-DRG 017, Autologous Bone Marrow Transplant without CC/MCC.

Two procedure codes are needed to correctly identify the rechargeable dual array deep brain stimulation system: codes 02.93 and 86.98. These cases are assigned to MS-DRGs 023, Craniotomy with Major Device Implant/Acute Complex CNS PDX with MCC or Chemo Implant, and 024 Craniotomy with Major Device Implant/Acute Complex CNS PDX without MCC. These MS-DRGs are assigned for those implants not specified as rechargeable.

Procedure codes 38.45, Resection of vessel with replacement, thoracic vessel, and 39.73, Endovascular implantation of graft in thoracic aorta, were removed from MS-DRGs 237 and 238. These procedures were added to MS-DRGs 216, 217, 218, 219, 220, and 221, all of which are cardiac valve MS-DRGs with and without cardiac catheterization.

Three new MS-DRGs were added to identify excisional debridement procedures. The new MS-DRGs, based on procedure code 86.22, Excisional debridement of wound, infection, or burn, will now be assigned to one of the following MS-DRGs:

- 570, Skin Debridement with MCC
- 571, Skin Debridement with CC
- 572, Skin Debridement without CC/MCC

Excisional debridement was previously assigned to MS-DRGs 573–578. These MS-DRGs will be maintained for skin graft procedures.

Several MS-DRGs under nutritional and metabolic diseases have updated titles. These include MS-DRG 640, Miscellaneous Disorders of Nutrition, Metabolism, and Fluids and Electrolytes with MCC; MS-DRG 641, Miscellaneous Disorders of Nutrition, Metabolism, and Fluids and Electrolytes without MCC; and MS-DRG 642, Inborn and Other Disorders of Metabolism.

Two procedure codes are necessary to identify the sleeve gastrectomy procedure for morbid obesity. The codes assigned are 43.82, Laparoscopic vertical (sleeve) gastrectomy, and 43.89, Other total gastrectomy. The sleeve gastrectomy procedure is assigned to MS-DRGs 619, 620, and 621, OR Procedures for Obesity, with MCC, with CC, and without CC/MCC, respectively. Procedure code 43.82 was added to the "noncovered procedures" edit of the Medicare Code Editor as laparoscopic sleeve gastrectomy and is not covered for Medicare beneficiaries.

CMS added discharge status code 66, Discharged/Transferred to Critical Access Hospital (CAH), to the grouper logic for MS-DRG 789, Neonate, Died or Transferred to Another Acute Care Facility. This was a correction from FY 2011.

CC/MCC Additions

New additions to the CC list for FY 2012 include:

- 294.21, Dementia, unspecified, with behavioral disturbance
- 358.30, Lambert-Eaton syndrome, unspecified
- 358.31, Lambert-Eaton syndrome in neoplastic disease
- 358.39, Lambert-Eaton syndrome in other diseases classified elsewhere
- 512.2, Postoperative air leak
- 516.5, Adult pulmonary Langerhans cell histiocytosis
- 539.01, Infection due to gastric band procedure
- 539.09, Other complications of gastric band procedure
- 539.81, Infection due to other bariatric procedure
- 539.89, Other complications of other bariatric procedure
- 596.81, Infection of cystostomy
- 596.82, Mechanical complication of cystostomy
- 596.83, Other complication of cystostomy
- 808.44, Multiple closed pelvic fractures without disruption of pelvic circle
- 996.88, Complications of transplanted organ, stem cell
- 997.32, Postprocedural aspiration pneumonia
- 999.32, Bloodstream infection due to central venous catheter
- 999.33, Local infection due to central venous catheter
- 999.34, Acute infection following transfusion, infusion, or injection of blood and blood products
- 999.41, Anaphylactic reaction due to administration of blood and blood products
- 999.42, Anaphylactic reaction due to vaccination
- 999.49, Anaphylactic reaction due to other serum

New additions to the MCC list for FY 2012 include:

- 284.11, Antineoplastic chemotherapy induced pancytopenia
- 284.12, Other drug-induced pancytopenia
- 348.82, Brain death
- 415.13, Saddle embolus of pulmonary artery
- 444.01, Saddle embolus of abdominal aorta
- 488.81, Influenza due to identified novel influenza A virus with pneumonia
- 516.4, Lymphangioleiomyomatosis
- 516.61, Neuroendocrine cell hyperplasia of infancy
- 516.62, Pulmonary interstitial glycogenosis
- 516.63, Surfactant mutations of the lung
- 516.64, Alveolar capillary dysplasia with vein misalignment
- 516.69, Other interstitial lung diseases of childhood
- 808.54, Multiple open pelvic fractures without disruption of pelvic circle
- 998.01, Postoperative shock, cardiogenic
- 998.02, Postoperative shock, septic
- 998.09, Postoperative shock, other

Hospital-Acquired Conditions

For FY 2012, CMS did not add contrast-induced acute kidney injury to the list of hospital-acquired condition (HAC) program as the diagnosis is difficult to identify with the current ICD-9-CM codes. The decision to add this diagnosis has been deferred until improved coding is available.

HACs were modified to reflect the FY 2012 code changes. These include the following new codes:

- 415.13, Saddle embolus of pulmonary artery (MCC)
- 539.01, Infection due to gastric band procedure (CC)
- 539.81, Infection due to other bariatric procedure (CC)
- 808.44, Multiple closed pelvic fractures without disruption of pelvic circle (CC)
- 808.54, Multiple open pelvic fractures without disruption of pelvic circle (MCC)

Reporting present on admission (POA) indicator "1" for codes that are exempt from POA will be affected by the implementation of the 5010 electronic transmittal standard, which is required on January 1, 2012. The 5010 standard removes the need to report POA indicator "1" for codes that are exempt from POA reporting. In this case, the POA field should be left blank. However, POA indicator "1" is still required on 4010 claims.

Affordable Care Act

The Affordable Care Act (ACA) mandated a readmission reduction program beginning in FY 2013. During the first year of the program, CMS will use three existing 30-day readmission measures: heart attack, heart failure, and pneumonia. Hospital performance will be assessed on readmissions using a three-year measurement period of July 1, 2008, through June 30, 2011.

CMS also finalized its definition of readmission as "occurring when a patient is discharged from the applicable hospital and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the initial hospitalization." The specified time period is 30 days.

ACA also mandated a long-term care hospital quality reporting program for FY 2014. Long-term care hospitals must begin reporting quality data on the following measures in October 2012:

- Urinary catheter-associated urinary tract infection
- Central line catheter-associated blood stream infection
- Pressure ulcers that are new or have worsened

New Technology Add-on Payments

In FY 2011 CMS approved the Spiration IBV Valve System for a maximum add-on payment of $3,437.50. The three-year anniversary for this will occur in the first half of the fiscal year; consequently CMS will discontinue this add-on payment. CMS also approved the CardioWest Temporary Total Artificial Heart System for a maximum add-on payment of $53,000 in FY 2011. The add-on payment is triggered with procedure code 37.52, condition code 30, and a diagnosis code of V70.7 reflecting a clinical trial. However, the three-year anniversary date will occur before FY 2012, and the add-on payment will be discontinued.

The Auto Laser Interstitial Thermal Therapy System, which is identified with procedure codes 17.61 and 17.62 and receives a maximum add-on of $5,300, will continue in FY 2012.

Reference

Centers for Medicare and Medicaid Services. "FY 2012 IPPS Final Rule." www.cms.gov/AcuteInpatientPPS/FR2012/list.asp.

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