FY 2018 Changes to Acute Care Hospital IPPS

By Donna Rugg, RHIT, CDIP, CCS

The fiscal year (FY) 2018 Hospital Inpatient Prospective Payment System (IPPS) final rule was released August 3, 2017 and impacted discharges beginning October 1, 2017. This is version 35 of the MS-DRG grouper. The Centers for Medicare and Medicaid Services (CMS) oversees the IPPS and each fiscal year reviews the current version, takes comments, and implements updates for the next fiscal year, which runs from October 1 to September 30.

It is important to note that this article will only cover some of the changes, so be sure to review the complete final rule on the CMS website. The link to the final rule is provided at the end of the article.

Reimbursement Adjustments

The overall average MS-DRG relative weights (RW) increased 0.0036 for FY 2018. There are 276 MS-DRGs with a RW increase, while 475 MS-DRG RWs have decreased and three MS-DRG RWs have stayed the same. MS-DRG 927 (Extensive Burns or Full-thickness Burns w/ MV>96 hrs w/ skin graft) had the largest RW increase (approximately +2.4885) and MS-DRG 215 (Other Heart Assist System Implant) had the largest RW decrease (approximately -3.2215).

MS-DRG Changes

This is the first year that the MS-DRG review process was based totally on claims data containing all ICD-10-CM and ICD-10-PCS codes (using FY 2016 MedPAR files). Now that there are two full fiscal years of data available, ICD-9-CM codes are no longer considered in this process. The MS-DRG changes are too numerous to cover completely here, so this article will highlight some of the changes.

Six procedure codes for insertion of radioactive elements into the mediastinum or pericardial cavity (0WHC01Z, 0WHC31Z, 0WHC41Z, 0WHD01Z, 0WHD31Z, 0WHD41Z) were removed from MS-DRGs 246-249, Percutaneous Cardiovascular procedures because they are not performed with percutaneous cardiovascular procedures. These six procedure codes are now assigned to MS-DRG 264 (Other Circulatory System O.R. Procedures).

Four ICD-10-CM diagnosis codes T49.5X1A, T49.5X2A, T49.5X3A, and T49.5X4A (Poisoning by ophthalmological drugs and preparations, initial encounter [accidental, intentional, assault and undetermined intent]) were reassigned from MS-DRGs 124 and 125 (Other Disorders of the Eye with and without MCC) to MS-DRGs 917 and 918 (Poisoning and Toxic Effects of Drugs with and without MCC). This is a more appropriate MS-DRG for these codes since they are poisonings and not eye disorders.

In recognition that total ankle replacements (TAR) are costly to perform, CMS has reassigned the six TAR ICD-10-PCS codes (0SRF0J9, 0SRF0JA, 0SRF0JZ, 0SRG0J9, 0SRG0JA, 0SRG0JZ) from MS-DRG 470 to MS-DRG 469. The title for MS-DRG 469 was changed to Major Hip and Knee Joint Replacement or Reattachment of LE w/ MCC or Total Ankle Replacement.

As a result, all TARs will be assigned to a DRG with an MCC even if one is not present because these cases require more resources than other cases assigned to MS-DRG 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity w/o MCC).

Code R53.2 Functional Quadriplegia has shifted from DRGs 052/053 to 947/948 (Signs and Symptoms with MCC and w/o MCC). This is a more appropriate DRG when there are also other sign and symptom codes. MS-DRGs 984-986, prostatic OR proc unrelated to principal diagnosis, moved all procedures to MS-DRGs 987-989 and deleted MS-DRGs 984-986. It was determined that not enough claims were seen to warrant separate DRGs for these cases.

The fourteen ICD-10-CM diagnosis codes that describe observation and evaluation of the newborn for suspected conditions ruled out (Z05.0-Z05.9) which are currently assigned to MS-DRG 794 (Neonate with Other Significant Problems) have been shifted to MS-DRG 795 (Normal Newborn). Cases that are assigned one of the codes from category Z05 as either a principal or secondary diagnosis (with a principal diagnosis from category Z38) will now result in MS-DRG 795.

There were no changes made to the list of hospital-acquired conditions (HACs) for FY 2018.

OR to Non-OR Procedure List Changes

Over 700 ICD-10-PCS procedure codes were shifted from the Operating Room (OR) Procedure list to the Non-OR Procedure list for FY 2018. Non-OR procedures are procedures that typically do not require operating room resources but can be performed at the bedside. Some of the procedures that are now considered non-OR procedures are:

- Endoscopic/transorifice fragmentation of the respiratory system body parts (0BF table)
- Endoscopic insertion of intraluminal devices into the trachea (0BH17DZ, 0BH18DZ)
- Several codes in the respiratory system w/revision of (0BW table) drainage, infusion, intraluminal, or monitoring devices
- Endoscopic excision of anus, via natural or artificial opening (0DBQ8ZZ)
- Insertion of intraluminal device into stomach via natural or artificial opening and via natural or artificial opening endoscopic (0DH67DZ, 0DH68DZ)
- Removal of feeding device (0DP table)

Some of the MS-DRGs most impacted by the shift of procedures from the OR to Non-OR list are MS-DRGs 853, 571, 632, 570, 464, 264, 981.

CC/MCC Changes to the MS-DRGs

CMS will be doing a detailed review of the CC and MCC lists for FY 2019. The last such comprehensive review of these lists was done in FY 2008 prior to the implementation of MS-DRGs. For FY 2018, approximately 86 ICD-10-CM diagnosis codes were added to the CC list. Primarily, these were codes already on the list but due to their revision for FY 2018 the list is updated. The CC list had approximately 12 codes deleted, which were codes that have been expanded for FY 2018 and are now subcategories and therefore no longer valid codes. Only one code was deleted from the MCC list (P29.3) because it was expanded for FY 2018 and no longer a valid code.

The following seven ICD-10-CM diagnosis codes (all new codes for FY 2018) were added to the MCC list:

- E11.10, Type 2 diabetes mellitus with ketoacidosis without coma
- E11.11, Type 2 diabetes mellitus with ketoacidosis with coma
- I21.9, Acute myocardial infarction, unspecified
- I21.A1, Myocardial infarction type 2
- I21.A9, Other myocardial infarction type
- P29.30, Pulmonary hypertension of newborn
- P29.38, Other persistent fetal circulation

The complete CC and MCC lists can be found on tables 6J (CC) and 6I (MCC) in the final IPPS rule in the *Federal Register*.

New Technology Add-On Payments

These are reviewed each year, resulting in changes and adjustments including the discontinuation, continuation, or addition of new technology add-on payments. For FY 2018 the following new technology items have been discontinued:

- Blinatumomab (BLINCTYO®)
- CardioMEMS™ HF (Heart Failure) Monitoring System
- MAGEC® Spinal Bracing and Distraction System (MAGEC Spine)
- Lutonix® Drug Coated Balloon TPA Catheter
- In.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter

New for FY 2018 are technology add-on payments for:

- Bezlotoxumab (ZINPLAVA™)
- EDWARDS INTUITY Elite ™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
- Ustekinumab (Stelara®)

Continuing for FY 2018 will be:

- Defitelio® (Defibrotide)
- GORE® EXCLUDER® Iliac Branch Endoprosthesis
- Praxbind® (Idarucizumab)
- Vistogard® (Uridine Triacetate)

Medicare Code Editor Changes

The Unacceptable principal diagnosis edit will now apply to the following codes for FY 2018:

- Bacterial and viral infectious agents B95.0 – B97.89
- Sequela of complication of pregnancy, childbirth, and the puerperium O94
- Coma R40.20 – R40.244
- SIRS codes R65.10 and R65.11
- Severe sepsis R65.20 and R65.21
- Almost 1,000 codes from categories T36-T50 (refer to table 6P.1.f. of the final rule for the specific codes)
- Postprocedural septic shock T81.12XD and T81.12XS
- Exercise counseling Z71.82
- At risk for dental caries Z91.841 – Z91.849

The 14 codes in category Z05 (Encounter for observation and evaluation of a newborn for suspected diseases and conditions ruled out) can now be reported as a principal diagnosis because the unacceptable principal diagnosis edit has been removed.

Hospital Readmission Reduction Program (HRRP)

A part of the Affordable Care Act requires CMS to reduce payments to hospitals that have excessive readmissions (within 30 days). This involves MCR fee-for-service inpatients admitted to an applicable hospital that have one of the following principal diagnoses or procedures: AMI, heart failure, pneumonia, COPD, CABG, or Total hip arthroplasty or Total knee arthroplasty. There's a readmission adjustment factor based on the hospital's risk-adjusted readmission rate during a three-year period that could reduce Medicare payments. Through the QualityNet secure portal account each hospital can obtain their FY 2018 Hospital Readmission Reduction Program results.

Hospital Value-based Purchasing Program

One previously adopted measure, PSI 90: Patient Safety for Selected Indicators from the Hospital VBP program, will be removed beginning in FY 2019. One new measure has been adopted beginning FY 2022, Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia. A modified version of Patient Safety and Adverse Events Composite (NQF #0531) has been adopted starting FY 2023.

The FY 2018 IPPS complete final rule and all tables (containing the new/revised/deleted ICD-10-CM and ICD-10-PCS codes, CC and MCC lists, etc.) are all publicly accessible online. This information can be found on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html.

Reference

Department of Health and Human Services. "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018

Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices." *Federal Register* 82, no. 155 (August 14, 2017). www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

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