Final Rule for FY 2008 IPPS: MS-DRGs and POA Top List in a Year of Major Change

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The final rule for the fiscal year 2008 inpatient prospective payment system (IPPS) went into effect October 1, 2007. The rule includes ICD-9-CM code changes, implementation of the new Medicare severity-adjusted (MS) DRG system, and a number of quality-related changes that affect how Medicare pays for inpatient hospital care. This article outlines some of these changes.

MS-DRGs

The Centers for Medicare and Medicaid Services (CMS) implemented the new MS-DRG system to better account for the difference in patient severity. Acute care hospitals began using MS-DRGs October 1, 2007, with a two-year transition for the relative weight calculation.

For FY 2008, half of the relative weight for each MS-DRG will be based on the CMS DRG relative weights, and the other half will be based on the MS-DRG relative weight. These blended weights will be 33 percent charge-based and 67 percent cost-based. In FY 2009, the relative weights will be based entirely on the MS-DRG relative weight and will be 100 percent cost-based.

The system consists of 745 MS-DRGs (an increase of 207 DRGs). The values range from 001–999. There are many unused numbers to accommodate future MS-DRG designations. Every CMS DRG (version 24 was used for Medicare discharges before October 1, 2007) has been completely renumbered. There is no correlation between version 24 DRG numbers and descriptions with the MS-DRG system. For example, version 24 DRG 470, Ungroupable, is now MS-DRG 999, Ungroupable. This will present challenges for any historical or trending activities.

In the proposed rule, CMS noted that the MS-DRG system could be replaced in FY 2009. The industry expressed great concern about the burden and expense that would be imposed by adopting one significant DRG reform and yet another one the following year. CMS responded that while there will be an opportunity for the public to comment, it is not expected that there will be persuasive public comment for CMS to adopt an alternative DRG system. For all intents and purposes, CMS has permanently adopted the MS-DRGs for IPPS. Of course, yearly updates and revisions will continue to be evaluated.

Three-Tier Split

In the CMS DRG system, many DRGs are split based on the presence or absence of a complication/comorbidity (CC). In the MS-DRG system, most DRGs are split into three based on whether any one of the secondary diagnoses has been categorized as a major complication or comorbidity (MCC), a CC, or no complication or comorbidity.

Examples of MS-DRGs that include all three tiers are:

- MS-DRG 193, Simple Pneumonia and Pleurisy with MCC
- MS-DRG 194, Simple Pneumonia with Pleurisy with CC
- MS-DRG 195, Simple Pneumonia with Pleurisy without CC/MCC

Not all MS-DRGs have the three-tier split. Some DRGs have combined CC/MCC, CC/non-CC, or MCC/non-MCC, while others will have only one DRG regardless of the presence or absence of a CC or MCC. Examples of MS-DRGs that have only two tiers are MS-DRG 231, Coronary Bypass with PTCA with MCC, and MS-DRG 232, Coronary Bypass with PTCA without MCC. An MS-DRG without tiers is MS-DRG 313, Chest Pain.

CC List

The current CC list has been revised extensively and will play an even greater role in MS-DRGs. The FY 2008 final rule assigns all ICD-9-CM diagnosis codes to non-CC, CC, or MCC. CCs should be assigned for:

- Acute conditions that can be separately coded. For example, acute myocardial infarction (410.xx) or acute respiratory failure (518.81).
- Chronic conditions that have separate advanced stages that can be separately coded. For example, chronic kidney disease has stage I, end-stage renal disease, with stages IV through end-stage renal disease designated as a CC or MCC.

Chronic conditions that have separately codeable acute conditions were removed from the CC list. The most noted exclusion from the CC list is congestive heart failure, which has several stages that can be more specifically coded (see table below).

Congestive Heart Failure CC Exclusions		
Code	**Description**	**CC Subclass Assignment**
428.21	Acute systolic heart failure	MCC
428.23	Acute on chronic systolic heart failure	MCC
428.31	Acute diastolic heart failure	MCC
428.33	Acute on chronic diastolic heart failure	MCC
428.41	Acute systolic and diastolic heart failure	MCC
428.43	Acute on chronic systolic and diastolic heart failure	MCC
428.1	Left heart failure	CC
428.20	Systolic heart failure NOS	CC
428.22	Chronic systolic heart failure	CC
428.30	Diastolic heart failure, NOS	CC
428.32	Chronic diastolic heart failure	CC
428.40	Systolic and diastolic heart failure NOS	CC
428.42	Chronic systolic and diastolic heart failure	CC
428.0	Congestive heart failure NOS	Non-CC
428.9	Heart failure NOS	Non-CC
The final rule for the FY 2008 IPPS excludes chronic conditions that have separately codeable acute conditions from the CC list. The most noted exclusion is congestive heart failure.		

It should be noted that increased specificity in documentation will be needed to accurately reflect consumed resources and the patient's stage of illness.

The list of MCCs was determined by considering other severity systems that use the MCC assignment. A detailed list of all CCs and MCCs can be found in tables 6J and 6I, respectively, in the final rule.

There are five conditions that will be considered MCCs when a patient is discharged alive:

- Ventricular fibrillation (427.41)
- Cardiac arrest (427.5)
- Cardiogenic shock (785.51)

- Other shock without mention of trauma (785.59)
- Respiratory arrest (799.1)

If the patient expires (UB-04 discharge status = 20), these conditions will be classified as non-CCs.

In addition to reclassification of the CC list, CMS has also updated the CC exclusion list. This list identifies conditions that will not be considered a CC or MCC for a given principal diagnosis. For example, pneumonia due to adenovirus (480.0) will not be a CC for pneumonia (486). Another example, urinary retention (788.20) is not a CC for benign prostatic hypertrophy (600.00). See table 6G for additions and table 6H for deletions of the CC exclusion list.

Hospital-Acquired Conditions and POA

The Deficit Reduction Act of 2005 (DRA) required that CMS select at least two preventable, hospital-acquired conditions that lead to the assignment of a higher-paying DRG by October 1, 2007. For discharges after October 1, 2008, hospitals will not receive additional payment when one of these conditions occurs during the patient's hospitalization. The case will be paid as though the condition was not present.

The DRA also requires hospitals to identify secondary diagnoses that are present on admission (POA) beginning October 1, 2007. The POA indicator is required for the principal and all secondary diagnoses in order to determine whether a selected condition developed during a hospital stay. Specific instructions on how to select and report the correct POA indicator are included in the "ICD-9-CM Official Guidelines for Coding and Reporting" and in CMS Transmittal 1240. [For more on POA, see the practice brief "Planning for Present on Admission" (*J AHIMA*, Nov-Dec 2007). Additional information is available at www.ahima.org/reimbursement [page no longer available].

More than 10 percent of all comments on the proposed rule dealt with hospital-acquired conditions or infections. CMS worked with public health and infectious disease experts from the Centers for Disease Control and Prevention to evaluate the initial list of 13 hospital-acquired conditions published in the proposed rule as well as some proposed new conditions. The following criteria were applied to select the final list of conditions:

- Coding: easily identified by unique ICD-9-CM codes
- Burden: high cost, high volume, or both
- Prevention guidelines: could reasonably have been prevented through the application of evidence-based guidelines
- CC/MCC: assignment of a case to a DRG that has a higher payment when the code is present as a CC or MCC
- Considerations: how condition meets statutory criteria in light of potential difficulties that CMS would face if the condition were selected

In the final rule, CMS lists the hospital-acquired conditions that it will use to meet the DRA requirements. How each condition meets the above criteria, as well as those that did not, is also discussed in detail. For FY 2009, beginning on October 1, 2008, cases with the following conditions (if the condition is the only CC or MCC on the case) will not be paid at a higher rate unless the conditions were present on admission:

- Catheter-associated urinary tract infection
- Pressure ulcers
- Object left in during surgery
- Air embolism
- Delivery of ABO-incompatible blood products
- Vascular catheter-associated infections
- Mediastinitis after coronary artery bypass graft (CABG) surgery (new)
- Falls and fractures, dislocations, intracranial and crushing injury, and burns (originally falls)

A complete list of all ICD-9-CM codes associated with the above conditions can be found at www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalAcqConTraumaCodes.pdf.

Given the changes coming to IPPS, hospitals may need to refine or implement a clinical documentation improvement plan to completely and appropriately identify the conditions that represent the patient's severity of illness and determine whether

conditions were or were not present on admission.

Base Rate Reductions Planned

Under MS-DRGs, hospitals will have financial incentives to improve documentation to ensure that a patient's severity of illness is accurately reflected. CMS acknowledges this and expects hospitals to make the change.

CMS will reduce base rates because of these anticipated improvements in documentation and coding, phasing in the adjustments over a three-year period. Based on legislation passed in early October (HR 3668), the reductions will be .6 percent in FY 2008, .9 percent in 2009, and 1.8 percent in 2010.

Reference

Centers for Medicare and Medicaid Services. "Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates." *Federal Register* 72, no. 162 (August 22, 2007). Available online at www.access.gpo.gov/su_docs/fedreg/a070822c.html.

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