IPPS Final Rule Changes for Fiscal Year 2019

By Moira Hunger, RHIT

Though hard to believe, a new fiscal year (FY) is already well underway. The Centers for Medicare and Medicaid Services (CMS) released the final rule for the Hospital Inpatient Prospective Payment System (IPPS) on August 17, 2018. All changes were effective with discharges beginning on October 1, 2018 and will end with discharges on September 30, 2019.

Clocking in at almost 2,000 pages, the IPPS Final Rule was a hefty read. All information on FY 2019's IPPS Final Rule, including tables, can (and should!) be accessed on the CMS website. The entire IPPS Final Rule with all of its charts and tables for FY 2019 can be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html.

Please bear in mind that this article is by no means a comprehensive discussion of the changes enacted this year, but rather a short overview of some of the coding highlights.

MS-DRG Changes

As pointed out in the *Federal Register* entry, ICD-10-CM/PCS and MS-DRG are both imperfect systems and are constantly being monitored and revised. To that end, the IPPS Final Rule brought both MS-DRG and ICD-10-CM/PCS changes, including:

- All pacemaker insertion procedures, even pacemakers considered to be "leadless," will be grouped together in MS-DRGs 260 – 262, Cardiac pacemaker revision except device replacement.
- Twelve procedure codes regarding repair and reposition of the intestines will be moved from MS-DRGs 329 – 331, Major small and large bowel procedures, to MS-DRGs 344 – 346, Minor small and large bowel procedures.
- The second quarter 2017 issue of *Coding Clinic* that set guidance for spinal fusions and fixations created around 100 codes that were eventually considered clinically invalid by CMS. As of October 1, 2018, these codes were deleted from ICD-10-PCS.
- MS-DRG 685, Admit for renal dialysis, has been deleted completely. All associated codes are to be moved to MS-DRGs 698 – 700, Other kidney and urinary tract diagnoses.
- CMS and 3M tackled the messy and complicated assignment of codes to MDC 14, Pregnancy, Childbirth and the Puerperium. The logic for the entire GROUPER in this category was rewritten so that it simplified and streamlined the assignment of the proper MS-DRG to be in line with the existing tiered severity structure that we're all familiar with in other parts of ICD-10-CM/PCS. In the end, this required deleting 10 existing MS-DRGs and establishing 18 new MS-DRGs.
- CMS also removed dilation and curettage procedures from MDC 14 and directed them to the appropriate MS-DRGs in MDC 13, Diseases and Disorders of the Female Reproductive System.
- Codes R65.10, Systemic inflammatory response syndrome (SIRS) of non-infective origin without acute organ dysfunction and code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infective origin without acute organ dysfunction have been re-assigned from MS-DRG 870/871 to MS-DRG 864, which has been retitled to read "Fever and Inflammatory Conditions."

The various changes for FY 2019 bring us to a total of 761 MS-DRGs in version 36.

GROUPER Logic in MDC 14

The initial analysis of MDC 14, Pregnancy, Childbirth and the Puerperium, revealed that the current structure of "delivery with complicating conditions" was not accurately reflecting the intended MS-DRG structure of "tiers of severity," so CMS went back to the beginning and completely changed the GROUPER logic. The existing MDC was broken out into "groups" of types

of procedures—either delivery, abortion, or other. Antepartum diagnoses were separated and received their own separate MS-DRGs. Those procedures that were considered non-essential to a delivery were moved to other MDC groups. This includes dilation or aspiration curettage (including for retained placenta) and, more surprisingly, repairs of third- and fourth-degree vaginal lacerations. These include repair of anus, rectum, and the anal sphincter. CMS argued that these specific procedures, as opposed to repair of the perineum muscle, could be expected to require a separate operating room episode from the delivery.

Once the definition of what does and does not constitute a "delivery" was established, the question of how to fit the current model of tiers of severity had to be applied. What is the starting point? Once the GROUPER sees a Principal Diagnosis from MDC 14, where does it go next? CMS settled on asking the GROUPER if there is a delivery code. Yes? What kind? Is there a sterilization done during the encounter? Are there other procedures done that do not fall into the MDC 14 procedure list? Using this logic, the new delivery MS-DRGs in MDC 14 are:

- MS-DRG 783, Cesarean Section with Sterilization with MCC
- MS-DRG 784, Cesarean Section with Sterilization with CC
- MS-DRG 785, Cesarean Section with Sterilization without CC/MCC
- MS-DRG 786, Cesarean Section without Sterilization with MCC
- MS-DRG 787, Cesarean Section without Sterilization with CC
- MS-DRG 788, Cesarean Section without Sterilization without CC/MCC
- MS-DRG 796, Vaginal Delivery with Sterilization with MCC
- MS-DRG 797, Vaginal Delivery with Sterilization with CC
- MS-DRG 798, Vaginal Delivery with Sterilization without CC/MCC
- MS-DRG 805, Vaginal Delivery without Sterilization with MCC
- MS-DRG 806, Vaginal Delivery without Sterilization with CC
- MS-DRG 807, Vaginal Delivery without Sterilization without CC/MCC

Non-delivery DRGs received similar logic if the GROUPER "sees" an abortion principal diagnosis on the chart. Was there an operative procedure done? If so, the GROUPER assigns the current MS-DRG of 770 or 779. No? Was the Principal Diagnosis antepartum? Postpartum? Were there any procedures done? New non-delivery MS-DRGs were consolidated into the following:

- MS-DRG 817, Other Antepartum Diagnoses with O.R. Procedure with MCC
- MS-DRG 818 Other Antepartum Diagnoses with O.R. Procedure with CC
- MS-DRG 819, Other Antepartum Diagnoses with O.R. Procedure without CC/MCC
- MS-DRG 831, Other Antepartum Diagnoses without O.R. Procedure with MCC
- MS-DRG 832, Other Antepartum Diagnoses without O.R. Procedure with CC
- MS-DRG 833, Other Antepartum Diagnoses without O.R. Procedure without CC/MCC

Coding professionals are encouraged to read this section, II.F.10, in the *Federal Register* entry for a more complete explanation and two excellent flowcharts illustrating the revised GROUPER logic.

New Technology

Nine new items have been included as eligible for new technology add-on payments in FY 2019:

- VYXEOS™
- GIAPREZA™
- VABOMERE™
- ZEMDRI™/Plazomicin
- Remede® System
- AndexXa™
- Sentinel® Cerebral Protection System™
- Aquabeam®
- Kymriah®/Yescarta®

Defitelio®, ZINPLAVA™, and Stelara® remain eligible for new technology add-on payments as well.

Meaningful Measures

CMS consolidated the number of measures hospitals are required to report under the various quality and value-based purchasing programs. All measures under the Inpatient Quality Reporting (IQR), Readmissions Reduction, Hospital-Acquired Conditions (HAC), and Value-Based Purchasing (VBP) programs were evaluated for administrative burden, outcome improvement, and duplication within the four programs. This review led to the removal of 18 measures; 21 measures that were in multiple programs have been consolidated to one program, which is being referred to as "de-duplication."

Healthcare-associated infection measures will still be removed from the IQR, but that has been delayed until December 31, 2019.

Post-acute Care Transfer and Special Payment Policy

Discharges to hospice care were included in the list of post-acute care transfer payment adjustments. No new MS-DRGs were added to the post-acute care transfer policy, but two MS-DRGs have been added to the special payment policy list: MS-DRG 023 and MS-DRG 024.

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 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims." *Federal Register* 83, no. 160 (August 17, 2018). www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf.

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