CMS releases 2009 IPPS final rule

Focus on patient safety means changes to quality measures, hospital acquired conditions

By Brian Murphy, CPC and Andrea Kraynak, CPC-A

CMS released its inpatient prospective payment system (IPPS) final rule for fiscal year (FY) 2009 on July 31, updating Medicare payments to hospitals and providing added incentives for hospitals to improve their quality of care.

The final IPPS rule updates payment policies and rates of the 3,500 hospitals paid under Medicare’s diagnosis related group (DRG) payment system. The finalized changes also aim to “promote the Administration’s goal of transforming Medicare to a prudent purchaser of health care services, paying for quality of services, not just quantity,” according to a July 31 CMS press release. It is estimated that the changes will increase Medicare payments to acute care hospitals by almost $4.75 billion.

New hospital acquired conditions

CMS finalized three new hospital acquired conditions (HAC), effective October 1. In addition to the current list of eight HACs, CMS has determined the following three conditions to be reasonably preventable through proper care:

- Surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity
- Certain manifestations of poor control of blood sugar levels, primarily diabetic hyperosmolarity, ketoacidosis, and hypoglycemia coma
- Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

By adopting these HACs CMS has shown it listened to public opinion in regards to the proposed conditions, and looked closely at which conditions would be reasonably preventable and evidence-based, says DeAnne W. Bloomquist, RHIT, CCS, a coding and compliance consultant and the president of Mid-Continent Coding, Inc., in Overland Park, KS.

As of October 1, a case will group to a lower weighted MS-DRG and Medicare will no longer pay the additional cost of the hospitalization if the following are true:

- The HAC is not present on admission (POA) but is acquired during the hospital stay (POA indicator of “N”) or if there is insufficient documentation to support that the condition was POA (POA indicator of “U”)
- The HAC is the only complication/comorbidity (CC) or major CC (MCC)

"Now is a good time for coders to insure their clinical familiarity with the conditions included in the expanded list of conditions and be able to understand and recognize the clinical signs and symptoms of some of these conditions," says Glenn Krauss, BBA, RHIA, CCS, CCS-P, CPUR, FCS, PCS, C-CDIS, a senior coding and chargemaster consultant for Quorum Health Resources in Brentwood, TN. "This heightened clinical awareness will best serve the coder because he or she will be able to recognize when clinical documentation is deficient and properly craft a physician query."

The 2009 IPPS final rule also contains several charts listing the codes that describe preventable HACs. For example, effective October 1, CMS adopted as final the new higher specificity ICD-9-CM codes used to identify pressure ulcer stages III and IV (MCCs) as HACs:

Pressure ulcers: ICD-9-CM codes code descriptor

- 707.23 Pressure ulcer, stage III
707.24 Pressure ulcer, stage IV

CMS also provided the following example of how reporting a Stage III pressure ulcer as a secondary diagnosis as POA vs. not POA can impact payment:

**Example 1**
Principal diagnosis
• Intracranial hemorrhage or cerebral infarction (stroke) with MCC: MS-DRG 064
Secondary diagnosis
• Stage III pressure ulcer (code 707.23 (MCC)), **POA: Y**
Final payment: $8,030.28

**Example 2**
Principal diagnosis
• Intracranial hemorrhage or cerebral infarction (stroke) with MCC: MS-DRG 064
Secondary diagnosis
• Stage III pressure ulcer (code 707.23 (MCC)), **POA: N**
Final payment: $5,347.98

It’s noteworthy that only Stage III and IV pressure ulcers will count as MCCs, says Robert Gold, MD, CEO of DCBA in Atlanta, GA. Proper documentation of the staging of ulcers is therefore of critical importance.

James Kennedy, MD, CCS, director of FTI Healthcare in Atlanta, GA agrees that providers must ensure physicians document the presence of Stage III and IV pressure ulcers. “A physician or other qualified provider must document these—it cannot be a wound care nurse or a floor nurse,” he says. “The physician also must designate whether it was present on admission.”

Kennedy emphasizes that the final rule referenced significant revisions affecting the coding of POA status in the 2009 ICD-9-CM Official Guidelines for Coding and Reporting that are forthcoming but are currently not posted on the CDC’s Web site. One area for revision cited is the issue of timeframe for POA identification and documentation of infections and organisms.

In addition, CMS has decided to finalize its proposed policy not to pay for HACs with the POA U indicator (insufficient documentation), because it believes this approach will encourage complete documentation, which will result in more accurate public health data. CMS recognizes that there are certain circumstances that dictate payment for conditions marked with a U. These include death, elopement (leaving against medical advice), and transfers. CMS will monitor the extent and circumstances surrounding the use of the POA U indicator and may propose the use of the patient discharge status codes to recognize these exceptions in the future.

**Changes to MS-DRG descriptions**

CMS finalized its proposed change to subdivide MS-DRG 245 (AICD lead and generator procedures) into the following MS-DRGs:

- MS-DRG 245 (AICD generator procedures): to include procedure codes 37.96, 37.98, and 00.54
- MS-DRG 265 (AICD lead procedures): to include procedure codes 37.95, 37.97, and 00.52

CMS also finalized changes to the descriptions for MS-DRGs 870, 871, and 872 to incorporate "severe sepsis". Its new descriptions read as follows:

- MS-DRG 870 (Septicemia or Severe Sepsis with Mechanical Ventilation 96+ Hours)
- MS-DRG 871 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours with MCC)
- MS-DRG 872 (Septicemia or Severe Sepsis without Mechanical Ventilation 96+ Hours without MCC)

CMS also assigned code 37.52 (now titled “Implantation of total internal biventricular heart replacement system”) from MS-DRG 215 to MS-DRGs 001 and 002 and removed 37.52 from the “Non-Covered Procedure” edit and assigned it to the “Limited Coverage” edit. It also revised the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System) by reordering MS-DRG 245 (AICD Generator Procedures) above new MS-DRG 265 (AICD Lead Procedures).

CMS did not publish Tables 6G and 6H (Additions to and Deletions from the CC Exclusion List, respectively) in the final rule because of the length of the two tables. Instead, CMS is making them available at the CMS Web site at www.cms.hhs.gov/AcuteInpatientPPS.

**Clinical documentation improvement**

CMS finalized a documentation and coding “adjustment” of -0.9% to the FY 2009 IPPS national standardized amount. But note that the IPPS payment reduction for FY 2009 is in reality a more painful -1.5%. This is because the -0.6% documentation and coding adjustments established in the FY 2008 IPPS final rule is cumulative with FY 2009.

This combined effect of a -1.5% reduction in total IPPS reimbursement can be countered with a strong clinical documentation improvement (CDI) program. In fact, CMS in the rule says that there is nothing wrong with such programs:

> As we stated in the FY 2008 IPPS final rule with comment period, we do not believe there is anything inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment as long as the coding is fully and properly supported by documentation in the medical record.

> The documentation and coding adjustment was developed based on the recognition that the MS-DRGs, by better accounting for severity of illness in Medicare payment rates, would encourage hospitals to ensure they had fully and accurately documented and coded all patient diagnoses and procedures consistent with the medical record in order to garner the maximum IPPS payment available under the MS-DRG system.

Note, however, that hospitals need to be careful of such statements, even from CMS, says Gloryanne Bryant, RHIA, CCS, senior director of corporate coding/HIM compliance for CHW in San Francisco.

“You have to read carefully these statements in the regulations, because it could be seen as an open door for the RACs [Recovery Audit Contractors]],” Bryant says. “Don’t misinterpret this statement and code to optimize—you have to have clinical documentation along with checks and balances in place, and I strongly encourage everyone to have compliance oversight of their documentation improvement program and query/clarification forms being used.”

“1.5% is a pretty large decrease. So you’re starting in the hole 1.5% for coding and documentation adjustment on your case mix before you even get started,” says Krauss. “So, if you don’t have a documentation improvement program, now is a good time to consider implementing one.”

**Changing quality measures**

The 2009 final rule also brings some changes to the Reporting Hospital Quality Data for Annual Payment Update Program. Currently hospitals must report 30 quality measures to qualify for a full
update to their FY 2009 payment rate. However, CMS has decided to add 13 new quality measures to the list, as well as retiring one of the existing measures. Hospitals are no longer required to report the pneumonia oxygenation assessment measure as of January 1, 2009.

The 13 new measures include the following:

- **Surgical Care Improvement Project (SCIP)**
  - SCIP Cardiovascular 2 Surgery Patients on a Beta-Blocker prior to arrival who received beta blocker during the perioperative period

- **Nursing Sensitive Measures**
  - Failure to Rescue

- **Readmission measures**
  - Heart Failure readmission (Medicare only)

- **AHRQ Quality Indicators: Inpatient Quality Indicators and Patient Safety Indicators**
  - Death among surgical patients with treatable serious complications
  - Iatrogenic pneumothorax, adult
  - Postoperative wound dehiscence
  - Accidental puncture or laceration
  - Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
  - Hip fracture mortality rate
  - Mortality for selected medical conditions (composite)
  - Mortality for selected surgical procedures (composite)
  - Complication/patient safety for selected indicators (composite)

- **Cardiac Surgery Measures**
  - Participation in a systematic database for cardiac surgery

CMS had originally proposed the addition of 43 new quality measures, but after the comment period, it decided to finalize only 13. “That’s going to help hospitals a lot, because adding [43] was going to be a lot of extra work. Having to add only 13 is a big help,” says Bloomquist. With the deletion of the oxygenation assessment measure, the total number of measures hospitals must report in 2009 will be 42, which is up from the current 30 measures. “That’s an increase of 12—an extremely manageable level for the hospitals,” says Bloomquist.

By law CMS must reduce payments to hospitals that do not successfully report quality measures by 2% from the percentage increase that would otherwise apply.

CMS also finalized two additional healthcare-acquired conditions for which it will no longer pay a higher DRG rate beginning in FY 2009 if not present on admission. They include:

- Certain manifestations of poor control of blood sugar levels
- Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures

The federal agency also expanded its surgical site infection measure and will no longer pay for surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity.

“While it may be some time before we can begin to assess the real impact of these steps on patient care, we are hearing from hospitals around the country about efforts they have undertaken in the past year to improve staff training and other measures to reduce the incidence of these preventable conditions,” CMS Acting Administrator Kerry Weems said in the press release. “And other payers, both public and private, are beginning to adopt similar policies in their payment systems. This is a win-win situation: better outcomes at less overall cost.”
Editor’s note: To view the final rule on the CMS Web site, visit www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf. To read the CMS press release, click here. The final rule will also appear in the August 19 Federal Register.

For more information on hospital reporting of quality measures visit the Hospital Compare Web site at www.cms.hhs.gov/HospitalQualityInits/25_HospitalCompare.asp.