What you need to know!

Medicare Severity DRGs:
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Changes in IPPS for FFY 2008:
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Objectives Medicare Severity DRGs

• Define MS-DRG’s and the rationale for their creation
• Identify differences between the current CC list and the “revised CC” list
• Differentiate between a MCC and a CC
• Review Hospital Acquired Conditions
• Interpret the role of Present on Admission
• Identify changes in reporting hospital quality data program
Background

• Medicare Payment Advisory Commission (MedPAC) previously recommended revision of the current DRG system to more fully capture differences in severity of illness

• CMS contracted with RAND corporation to evaluate severity-adjusted DRG systems
Severity-Adjusted DRG System

- CMS will replace the current 538 DRG system with 745 Medicare-Severity diagnosis related groups (MS-DRGs).
- The system is based on the current DRG system.
- MS-DRGs represent comprehensive approach to applying severity of illness stratification for Medicare patients throughout the DRGs.
Complications and Comorbidities

- Most comprehensive review of the CC list since its creation
- Nearly 80% of patients now have a CC
  - The list has lost much of the power to discriminate hospital resource use
  - Better secondary diagnosis coding
  - Reduction in LOS
  - Increased post acute care or outpatient services
Current State

- 115 DRGs split based on the presence or absence of a CC

- Except for new diagnosis codes that have been added, the list is virtually the same as originally created
Revised CC List

- Modify the current CC list from 3,326 diagnosis codes to a “revised CC list” of 2,583 codes
  - Reviewed 13,549 secondary diagnosis codes
- Reduced the percentage of patients with at least one CC to 41.24%
Criteria for inclusion

• Substantially increased hospital resource use
  – Intensive monitoring
  – Expensive and technically complex services
  – Extensive care requiring a greater number of caregivers

• Required consistently greater impact on hospital resource
Criteria

• Removed chronic diseases without a significant acute manifestation
  – Exception: the chronic disease is associated with extensive debility

• Essentially comprised of
  – Significant acute disease
  – Acute exacerbation of significant chronic diseases
  – Advanced or end stage chronic disease
  – Chronic diseases with associated extensive debility
Examples

• Chronic Renal Disease
  – Stage IV, V or ESRD (codes 585.4-585.6) are designated CC
  – Stage I – III are non CCs (codes 585.1-585.3)

• Acute Diseases
  – AMI, CVA, ARF, pneumonia, acute respiratory failure, septicemia
CC’s Further Defined

- MCC—major complication or comorbidity
  - CC in the revised CC list
  - Identified as a major CC in AP-DRG and was an APR-DRG default severity level 3 (major) or 4 (extensive)
CC’s Further Defined

• CC—complication or comorbidity
  – Any diagnosis that did not meet the criteria of MCC or Non-CC

• Non-CC—non complication or combordity
  – Non-CC in the revised CC list
  – AP-DRG non-CC and APR-DRG default severity level 1
Additional Considerations

• CMS’ medical consultants identified specific clinical situations in which the diagnosis should not be considered a CC

• Each diagnosis for which Medicare data were available was evaluated

• Diagnoses closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died.
  – MCC if patient lives
  – Non-CC if patient dies
Exclusion to MCC or a CC

• External Cause of Injury and Poisoning codes (E codes)
  – A separate diagnosis code that describes the exact nature of an injury (i.e. fracture, contusion)

• Congenital codes
  – Should the congenital abnormality lead to medical problems that require hospitalization the exact nature of the condition would be evaluated.
Examples of Changes

- **Current CC**
  - 585.1 – 585.9 Chronic kidney disease, stage I through V, end stage renal disease, unspecified

- **MCC**: 585.6 End Stage Renal Disease

- **CC:**
  - 585.4 CKD, stage IV
  - 585.5 CKD, stage V
Examples of Changes

• The precise type of heart failure must be specified in order for an MCC or a CC to be assigned under the proposed changes
  – 428.0 Congestive heart failure, NOS
  – 428.9 Heart failure, NOS
  – Proposed to be removed from the revised CC list
MS-DRGs

• Consolidation of existing DRGs into new base MS-DRGs

• Subdivision of each base DRG into subclasses
Criteria for Subdividing MS-DRGs

- A reduction in variance of charges of at least 3 percent
- At least 5 percent of the patients in the MS-DRGs fall within the CC or MCC subgroup
- At least 500 cases are in the CC or MCC subgroup
- At least a 20% difference in average charges between subgroup
- A $4,000 difference in average charges between subgroups
Three Alternatives

• MS-DRGs with three subgroups (MCC, CC, and non-CC)
• Two different types of subgroups for MS-DRGs
  – MCC subgroup but the CC and non-CC subgroups combined
    • With MCC and Without MCC
  – Non-CC subgroup but CC and MCC subgroups combined
    • With CC/MCC and without CC/MCC
Other Considerations

• 1.2% Decrease in operating and capital payments in FY08
  1.8% FY09 & FY10
  – To offset changes in coding and documentation behavior (Refer to next slide for update)

• This proposed rule also affects Long-term acute care hospitals
  – MS-LTC-DRG

• Postacute Care Transfer
  – MS-DRGs affected by this policy will need to be identified
  – Each MS-DRG that shares a base MS-DRG would be a qualifying DRG if one of the MS-DRGs that shares the base MS-DRG qualifies
What does Abstinence Education have to do with it?

- House Bill 3668 “TMA, Abstinence Education, and QI Programs Extension Act of 2007” was passed by Congress and signed into law 9/29/2007 by President Bush.

- Section 7 of the Act decreased the size of the Behavior Offset related to the implementation of MS-DRG for FFY 2008 from (1.2%) to (0.6%) and for FFY 2009 from (1.8%) to (0.9%).

- CMS can and most likely will adjust for actual impact of change in CMI in FFY 2010-2012.
Bad News

– HIPAA requires CMS to accept up to 25 diagnoses and 25 procedure codes on 837i.
– HIPAA does not require that CMS process 25 and 25
– Currently, CMS uses MedPAR data (9 diagnoses, 6 procedures) to evaluate IPPS changes and will continue in FY08.
Hospital Acquired Conditions

• Deficit Reduction Act of 2005
  – Passed December 2005

• Reduces payments to hospitals in some cases when the patient acquires a complication such as an infection during a hospital stay
Deficit Reduction Act 2005

- Secretary is required to select at least two conditions that are:
  - High cost, volume or both
  - Result in the assignment of a case to a higher payment when present as a secondary diagnosis
  - Could have been prevented through the application of evidence-based guidelines
Criteria for Selection for Hospital Acquired Conditions

• Coding
  – Conditions that have (or could have) a unique ICD-9-CM code that clearly describes the condition

• Burden
  – High cost or high volume or both

• Prevention guidelines
  – Conditions that could reasonably have been prevented through the application of evidence-based guidelines
Criteria for Selection for Hospital Acquired Conditions

• CC
  – Codes that result in assignment of the case to a DRG that has a higher payment when the code is present as a secondary diagnosis

• Considerations
  – CMS evaluated each condition according to how it meets the statutory criteria in light of the potential difficulties they would face if the condition was selected
Proposed Conditions

- Catheter-associated urinary tract infections
- Decubitus ulcers
- Serious preventable event
  - Object left in surgery
  - Blood incompatibility
  - Air embolism
- Staph Aureus septicemia
Proposed Conditions

- Ventilator-associated pneumonia and other types of pneumonia
- Vascular catheter-associated infections
- Clostridium Difficile-Associated Disease
- Methicillin-Resistant Stap. Aureus (MRSA)
- Surgical site infections
- Serious preventable event-wrong surgery
- Falls
Selection of Conditions

• Serious Preventable Events
  – Object Left in during Surgery
    • 998.4 Foreign body accidentally left during a procedure
  – Air Embolism
    • 999.1 Complications of medical care, NOS, air embolism
  – Blood incompatibility
    • 999.6 Complications of medical care, NOS, ABO incompatibility reaction
Selection of Conditions

• Surgical site Infection-Mediastinitis after CABG
  – 998.59 Other postoperative infection
  – 519.2 Mediastinitis and 36.10-36.19

• Vascular Catheter-Associated Infection
  – 996.62 Infection due to other vascular device, implant, and graft
  – 999.31 Infection due to central venous catheter
Selection of Conditions

- **Hospital Acquired Injuries-**
  - Fractures (800-829)
  - Dislocations (830-839)
  - Intracranial injury (850-854)
  - Crushing Injury (925-929)
  - Burns (940-949)
  - Other Unspecified Effects of External Causes (991-994)

- **Use of fall E codes (E884.2-E884.6)**
Potential for FY 2009

• Staph Aureus Bloodstream Infection/Septicemia
• Ventilator Associated Pneumonia (VAP) and Other Types of Pneumonia
• Deep Vein Thrombosis (DVT)
Further Analysis

- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Clostridium Difficile-Associated Disease
- Wrong Surgery
Selection of Conditions

• Catheter Associated Urinary Tract Infections
  – 996.64 and any of the UTI codes

• Pressure Ulcers
  – 707.00-707.09
Present on Admission (POA)

- Acute care IPPS hospitals are required to submit POA indicator effect 10/1/2007
  - Information will not be used in claims processing until January 1 2008
- Instructions for selecting the correct POA indicator are part of the ICD-9-CM Official Guidelines for Coding and Reporting
Definition of POA

- Present on admission is defined as present at the time the order for inpatient admission occurs—conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered as present on admission.
POA Guidelines

- Not intended to:
  - Replace any of the guidelines in the main body of the ICD-9-CM Official Guidelines for Coding and Reporting
  - Provide guidance on when a condition should be coded

- Documentation by any provider involved in the care and treatment of the patient may be used to support POA indicator assignment
  - Provider means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.
Reporting Options

- **Y** = Yes (present at the time of IP admission)
- **N** = No (not present at the time of IP admission)
- **U** = Unknown (insufficient documentation)
- **W** = Clinically undetermined (provider is unable to clinically determine)
- Unreported/Not used (exempt from POA)
Examples of Yes Indicator

- Any condition the provider explicitly documents as being present on admission
- Conditions diagnosed prior to admission
  - Hypertension
  - Diabetes
- Conditions diagnosed during the admission that were clearly present but not diagnosed until after admission
- Conditions that develop during an outpatient encounter prior to a written order for IP admission
Examples of No Indicator

- Provider explicitly documents the condition as not being present on admission
- Inconclusive final diagnoses (Possible, probable) that are based on symptoms or clinical findings that were not present on admission
  - Same for impending, threatened conditions
- Any part of the combination codes was not present on admission
Unclear or Undetermined

• Documentation Unclear
  – Used in limited circumstances
  – Query is encouraged

• Clinically undetermined
  – It can not be determined whether or not the condition was POA
  – Example:
    • Sepsis
Clinical Example

- Patient presents to the emergency room with shortness of breath and chest pain. He has a past medical history of coronary artery disease for 2 years. He is admitted for workup and found to have MI. Day 2 progress note states: 2 episodes of non sustained ventricular tachycardia. Final diagnoses are:
  - Acute anterior wall myocardial infarction
  - Coronary artery disease
  - Non sustained ventricular tachycardia
Reporting of Hospital Quality Data

• Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program
  – Established with 10 quality measures

• Adopted 6 additional quality measures to be reported to be eligible for full market basket for FY 2008
Additional Measures

- HCAHPS survey
- Surgical Care Improvement Project (SCIP) measures
  - Venous thromboembolism prophylaxis ordered for surgery patients
  - Venous thromboembolism prophylaxis within 24 hours pre/post surgery
  - Prophylactic antibiotic selection for surgical patients
- Mortality (Medicare patients)
  - Acute MI 30-day mortality
  - Heart failure 30-day mortality
  - Pneumonia 30-day mortality
• FY 2007
  – 21 measures currently

• FY 2008
  – 6 additional
  – 27 total measures

• FY 2009
  – Proposing 5 additional measures
    • Pneumonia 30 day mortality (medicare)
    • Cardiac surgery patients
    • Surgery patients
  – 32 total measures

• Future
  – 18 measures and 8 measure sets from which additional quality measures could be selected for inclusion
Value Based Purchasing Program

• Build on the existing measures and the data submission, validation, and public reporting infrastructure of the RHQDAPU program.

• While the program is authorized by the Deficit Reduction Act, further legislation will be required to establish and implement it.
Questions
Objectives
Changes in IPPS for FFY 2008

• Changes impacting the Wage Index
• Changes to IME/GME rules
• Disclosure of Hospital Ownership
• EMTALA during certain disasters
• Emergency Services
• Medicare Advantage (Part C) in the DSH calculation
Outlier Threshold

- The statute requires that the Secretary set the cost threshold so that outlier payments for any year are projected to be not less than 5 percent or more than 6 percent of total operating DRG payments plus outlier payments.
- Historically, the Secretary has set the cost threshold so that 5.1 percent of estimated IPPS payments are paid as outliers.
- FY 2007 level of $24,485. CMS reduced the FY 2008 outlier threshold to $22,460.
- Increased sensitivity of MS-DRG to pay for most severe cases caused reduction.
Occupational Mix Adjustment

- As was discussed the FY 2007 final IPPS rule the Occupational Mix Adjustment to the wage index will be based on the 6 months of survey data collect from 1\textsuperscript{st} - 2\textsuperscript{nd} quarters of calendar 2006.

- Hospital’s not submitting data will be calculated based occupational mix factor of 1.0000.

- Hospital’s that submitted data for only 1 of the 2 quarters will be calculated based on the submitted quarter.

- CMS is still considering 1-2\% reduction for “nonresponsive hospital” for future years, no reduction for FY 2008.
Contract Labor for Indirect Patient Care Services - Calculation of Wage Index

• Beginning October 1, 2003 (FY 2004), the cost report was modified to provide for the collection of cost and hours data for the four identified contract indirect patient care services.

• CMS added 4 new line items to Worksheet S-3, Part II:
  – Line 9.03 (Contract management and administrative services);
  – Line 22.01 (Contract A & G services);
  – Line 26.01 (Contract housekeeping services);
  – and Line 27.01 (Contract dietary services).
Expiration of the Imputed Rural Wage Index Floor

• In FY 2007, 40 hospitals in 10 urban areas received higher wage indices due to the imputed floor policy: Massachusetts (10 hospitals in 2 areas); New Jersey (30 hospitals in 8 areas); Rhode Island (no areas and no hospitals).

• In FY 2008 Massachusetts has a rural hospital.

• CMS has decided to allow a transition of 2 years, as such the imputed rural floor will remain in effect for FFY 2008 and but will not longer be applied to all urban states in FFY 2009.

• CMS will use the unweighted average of the wage indices from all CBSAs that are contiguous to the rural counties of the State to compute the rural wage index when a new hospital opens and there are no other data available to calculate the rural wage index.
Reclassifications under Section 508 of Pub L. 108-173

• Section 508 expires 9/30/2007 and will not be further extended. Thus, it will not be applicable to FY 2008.

• There are attempts to revive 508 via the legislative process.
Out Migration Adjustment

- Provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index.

- Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment.

- Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index.

- CMS has decided to use post reclassified wage index data to calculate the outmigration factor, in part due to the application budget neutrality factor.
Capital IPPS Payments

- CMS is updating to the capital standard Federal rate for urban and rural hospitals will be 0.9 percent. CMS anticipate a full update to in FY 2009.
- CMS has elected to discontinue the 3.0 percent additional payment that has been provided to hospitals located in large urban areas.
- CMS has decided to phase out the capital IPPS teaching adjustment over a 3-year period, with a 50-percent reduction beginning in FY 2009.
MedPac recommends based BLS wage index

- In June 2007 MedPac made final recommendations to Congress on the wage index process.

- Three recommendations were adopted with 15 votes in favor 0 votes opposed and 2 absent commissioners.

- It would eliminate the current wage index system and replace it with one based on Bureau of Labor Statistics survey data.
IME Adjustment

- CMS proposed that vacation and sick time from the intern and resident FTE count for IME and GME.
- “We acknowledge that removing vacation and sick leave time from the denominator of the FTE count for both IME and direct GME could have some impact on the FTE count, but the impact is fact-specific. In some cases, it would result in a lower FTE count, and in some cases, it would result in a higher FTE count.” Source: CMS 1588-P pg 504
- “Despite our continued belief that vacation, sick leave, and other approved leave is neither a patient care nor a non-patient care activity, we acknowledge the significant concerns raised by the commenters regarding the administrative burdens associated with the implementation of the proposed policy.

Therefore, we will not be finalizing the proposed policy to remove vacation and sick leave from the FTE calculation at this time.”
Disclosure of Physician Ownership in Hospitals

• CMS has decided to amend §489.3 to define a “physician-owned hospital” as any participating hospital (as defined in §489.24) in which a physician or physicians have an ownership or investment interest.

• CMS except from the definition of a “physician-owned hospital” those hospitals in which the physician ownership is limited to holding publicly traded securities or mutual funds that satisfy the requirements of the exceptions under §§411.356(a) or (b)
Disclosure of Physician Ownership in Hospitals

- CMS will require that patients be given written notice that a hospital is physician-owned and that the list of physician owners is available upon request.
- The notice would have to meet the following:
  - in a manner reasonably designed to be understood by all patients,
  - the fact that the hospital meets the Federal definition of a “physician-owned hospital” and
  - that patients will be provided the list of the hospital’s physician owners upon request.
Disclosure of Physician Ownership in Hospitals

• CMS has decided that hospitals would be required to ensure that all physician owners who are also members of the hospital’s medical staff disclose, in writing, their ownership interest in the hospital to all patients they refer to the hospital, as a condition of continued medical staff membership.

• Patient disclosure would be required at the time a physician makes a referral.
Changes to Emergency Medical Treatment and Labor Act (EMTALA)

CMS amended the EMTALA regulations as they relate to actions taken in an emergency area during either a national emergency declared by the president or a national public health emergency declared by the Secretary of HHS. Currently, the regulations specify that EMTALA sanctions for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area.

To implement *Pandemic and All Hazards Preparedness Act*:

1. EMTALA sanctions that do not apply are those for either the inappropriate transfer before stabilizing or those for the direction or relocation to an alternate location.

2. Clarify that a waiver of EMTALA sanctions is limited to a 72-hour period beginning with the implementation of a hospital disaster protocol. Except, if a public health emergency involves a pandemic infectious disease then waiver will remain in effect until the termination of a public health emergency.
CMS will require ALL hospitals that do not have physicians available on the premises 24 hours per day, 7 days per week (24/7) to inform patients of that limitation prior to their receiving an inpatient or outpatient service.

- CMS did not give specific language for the notice, however it has required that the notice must specifically state that the hospital does not have physicians on the premises 24/7.
- The notice also must describe how the hospital will meet any emergency service needs when a doctor is not on the premises.
- The disclosure would be required at the point of registration and/or preadmission testing.
- Effective October 1, 2007
Medicare Advantage days in DSH calculation

• The final rule clarifies that Medicare Advantage (MA) days are to be included in the Medicare fraction of the DSH calculation.

• As of January 7, 2008, hospitals must begin to submit "no pay" bills to their Medicare contractor for stays by MA beneficiaries.

• This will allow for the days of those stays to be eventually captured in the DSH calculations.
• Link to IPPS rule

• Official Guidelines for Coding and Reporting

• The proposed plan, “Options Paper”
http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBOptions.pdf

• There is a crosswalk between CMS-DRGs and MS-DRGs however due to the multiple severity levels based on CC and MCCs, claims would need to be regrouped with the MS-DRG grouper to get the most accurate answer.

• National Technical Information Service has made DRG Definitions Manual and DRG software.
http://www.ntis.gov/products/families/cms/grouper.asp