

## CMS Releases Inpatient Prospective Payment System Final Rule

On July 31, 2008, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2009 Medicare Hospital Inpatient Prospective Payment System (IPPS) final rule. CMS projects that the changes in the final rule will increase average inpatient payments to hospitals in FY 2009 by 4.7 percent.

Two years ago, in the FY 2007 IPPS final rule, CMS finalized a comprehensive restructuring plan to refine current diagnosis-related groups (DRGs) to account more accurately for differences in severity of illness, creating new Medicare severity-adjusted DRGs (MS-DRGs). Under the original Medicare DRG system, a hospital received a fixed payment, based on charges, for treating a case assigned to each DRG. CMS refined the DRG system upon recommendation from the Medicare Payment Advisory Commission (MedPAC), which concluded that charge markups from different hospitals caused a bias in payments, which are calculated using charge-based DRG weights. To give hospitals time to prepare for the new MS-DRG system, CMS initiated a two-year transition that shifts from DRG weights based on charges to weights based on costs, by blending payment based on the old system with payment based on calculations from the new system.

CMS payments in FY 2009 will be based on 100 percent of costs, marking the end of CMS's transition that blended costs and charges.

In its final rule, CMS also addresses proper billing in the

inpatient setting. In response to a question about whether blood transfusions should be included in a routine cost center charge or billed separately, CMS provided clarification by distinguishing between the location of the transfusion. For transfusions occurring in routine cost centers, "the provider must consider the established practice of the same class of providers in the same state as to whether to include blood transfusion in the routine service charge." For transfusions occurring in the operating room, emergency room, or other ancillary cost centers, providers should bill a separate charge for the transfusion procedure under revenue code 0391. It is important to remember that billing requirements under Medicare in the inpatient setting are different from those in the outpatient setting.

### CMS will Deny Higher Reimbursement for Eleven Conditions in FY 2009

As part of its hospital acquired conditions (HAC) initiative, CMS has finalized its proposal to reimburse hospitals at a lower rate for certain secondary diagnoses if the conditions were acquired during an inpatient stay. Effective October 1, 2007, hospitals were required to submit present on admission (POA) indicator information in Medicare claims for all primary and secondary diagnoses. POA indicators allow Medicare to differentiate between secondary conditions that developed during a hospital stay from those that were present upon admission.

For a condition to be selected as a HAC, it must (a) be high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) be reasonably preventable through the application of evidence-based guidelines.

Eleven conditions were finalized in the FY 2009 IPPS final rule. These conditions include the following: foreign object left in after surgery, air embolism, blood incompatibility, catheter-associated urinary tract infection, stage III and IV pressure ulcers, vascular catheter-associated infections, certain types of falls and trauma, surgical site infections following certain elective procedures, certain manifestations of poor control of blood sugar levels, deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures, and surgical site infection in the chest (mediastinitis) after coronary artery bypass graft surgery.

Additional information about CMS's HAC initiative can be accessed at <http://www.cms.hhs.gov/HospitalAcqCond/>.

### Did you know...

#### that CMS has selected First Coast Service Options (FCSO) as the Part A/B Medicare Administrative Contractor (MAC) for Jurisdiction 9 (J9)?

On September 12, 2008, CMS announced that FCSO will serve as the A/B MAC for J9, which includes Florida, Puerto Rico, and the Virgin Islands. FCSO will begin implementation activities immediately and will assume full responsibility for its claims processing work no later than March 2009. FCSO is the ninth A/B MAC to be awarded by CMS.



## CMS Expands its List of Hospital Quality Measures for FY 2009

CMS has finalized its expansion of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), which is part of a continuing initiative intended to provide consumers with quality-of-care information to make more informed decisions about their care, while providing incentives for hospitals and clinicians to improve the quality of inpatient care provided. This initiative reduces the amount a hospital is paid if it does not voluntarily report on standardized quality measures. Hospitals that submit specified quality data will receive the full market basket increase (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) of 3.6 percent for FY 2009, while hospitals that do not report this information will be subject to a 2.0 percent reduction to the update, lowering the increase to 1.6 percent.

The FY 2009 IPPS proposed rule would have increased the total number of quality measures from 30 to 72 measures; however, in the final rule, CMS decided to finalize only 13 of the proposed measures, setting the final total at 42 measures. None of the original or new measures impact blood or blood products. The new measures include:

- Surgical Care Improvement Project (SCIP) Cardio-

vascular 2, surgery patients on a beta blocker prior to arrival who received a beta blocker during the peri-operative period

- Heart failure (HF) 30-day risk standardized re-admission measure (Medicare patients)
- Failure to rescue (Medicare patients)
- 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)
- Participation in a systematic database for cardiac surgery

Hospitals must report on these measures in 2009 to receive the full market increase in 2010.

For the complete list of measures required for the 2010 update, visit this Website: [http://www.cms.hhs.gov/HospitalQualityInits/08\\_HospitalRHQDAPU.asp](http://www.cms.hhs.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp)

## FDA Orders Label Changes for ESAs

On July 30, 2008, the US Food and Drug Administration (FDA) ordered changes to the labels for Aranesp®, Procrit®, and Epogen®. This mandate marks the agency's response to recommendations by the Oncologic Drug Advisory Committee (ODA) on erythropoiesis-stimulating agents (ESAs) in March of 2008.

This also represents the first time that the agency has acted on a 2007 law found in the FDA Amendments Act, that empowers the agency to order changes in a drug's prescribing information. Previously, the FDA could only negotiate with a drug's manufacturer to change the label.

The new labels state that treatment with ESAs should not begin until a patient's hemoglobin drops to 10 g/dL. Additionally, language was removed that implied that it was safe to continue treating patients until their hemoglobin rose to 12 g/dL. The new label clarifies that the dose should be withheld if hemoglobin exceeds 12 g/dL. The label also will state that the drugs should not be used with patients who are expected to be cured of cancer. These restrictions were added due to concerns about possible shortened survival, increased disease progression, and thrombotic events associated with ESAs in some patients with cancer. The new labels do not advise against use of the drugs for patients with breast cancer or head and neck cancer. ODAC's earlier recommendations called for such an advisory because the drugs' risks seemed to be stronger for both types of cancers.

For additional information on the FDA's label changes, visit this Website: <http://www.fda.gov/cder/drug/infopage/RHE/default.htm>

## CMS Finalizes Proposal to Cut IVIG Pre-Administration Fee

On November 1, 2008, CMS issued the Medicare Physician Fee Schedule (MPFS) final rule, which includes a change to the way intravenous immune globulin (IVIG) products are paid in the physician's office. As discussed in its FY 2009 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule, the same change applies to the hospital outpatient setting.

Since 2006, Medicare has reimbursed physicians an additional fee related to pre-administration services for IVIG products. This payment was adopted by CMS as a temporary measure to reimburse physicians for the additional resources needed to locate and acquire IVIG supplies during a period in which IVIG products were thought to be in limited supply. In both rules, CMS has concluded that the market issue with IVIG seems to have been resolved. Furthermore, the cost data that CMS has gathered for the services described by HCPCS code G0332 since calendar year (CY) 2006 indicate that the cost of the services is relatively low and meets historical criteria for packaged payment.

The changes finalized in the OPPS and MPFS rules will be effective January 1, 2009. Additional information regarding changes to the pre-administration fee can be found in both rules, which can be accessed by visiting the following Website: <http://www.cms.hhs.gov/apps/media/>

