

CMS Releases Inpatient PPS Proposed Rule

On May 1, 2009, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2010 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule. According to the proposed rule, the average inpatient hospital payment is expected to decrease by 0.5 percent per case. While it is rare for hospitals to receive a negative update, CMS attributes the payment decrease to the changes in hospital coding practices triggered by the transition in 2008 to Medicare severity-adjusted diagnosis-related groups (MS-DRGs). According to CMS, hospitals have coded more precisely under MS-DRGs, which has resulted in increased payments that must be offset with a negative payment update in order to maintain budget neutrality.

As part of its hospital acquired conditions (HAC) initiative, CMS reimburses hospitals at a lower rate for certain secondary diagnoses if the conditions were acquired during an inpatient stay. CMS has not proposed any additions or deletions HAC list. The current list of HACs remains in effect in FY 2010 and contains these items:

1. Foreign object inadvertently left in after surgery
2. Air embolism
3. Blood incompatibility
4. Catheter-associated urinary tract infection
5. Stage III and IV pressure ulcers
6. Vascular catheter-associated infection
7. Surgical site infections (SSI) including: mediastinitis after coronary artery bypass graft surgery; SSI following certain elective procedures; and SSI following bariatric surgery for obesity
8. Certain types of falls and trauma
9. Certain manifestations of poor control of blood sugar levels
10. Deep vein thrombosis or pulmonary embolism following total knee and hip replacement
11. CMS has proposed four new quality measures to its 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. Adherence to the specified measures provides 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. In FY 2010, hospitals will need to report 4 new quality measures in addition to the current 43 measures in order to qualify for the full market basket increase in FY 2011. Hospitals that do not report this information will be subject to a 2.0-percentage point reduction to the payment update.

CMS proposes a market basket update of 2.1 percent for 2010. The market basket measures the inflation in the costs of resources used by hospitals (including blood and blood products), to deliver care. Various categories of resources are used to determine the market basket update. The proposed rule contains three new cost categories, including one for blood and blood products, which have previously been accounted for through the “miscellaneous” cost category. Although blood and blood products are not reimbursed separately, CMS uses the market basket update to establish payment rates, which in turn, affect reimbursement for these products.

Comments related to guidance proposed in the IPPS proposed rule must be received by June 30, 2009. More information on the IPPS proposed rule is available at:

<http://www.cms.hhs.gov/AcuteInpatientPPS/FY2010RULE/list.asp#TopOfPage>

Did you know...

that Congress has proposed a bill increasing reimbursement for IVIG administration?

The Medicare Patient IVIG Access Act of 2009 has been introduced in the U.S. House of Representatives, to increase reimbursement for services related to IVIG products. The bill's introduction follows CMS's recent decision to cut reimbursement that directed additional payment to physicians for the resources needed to locate and acquire IVIG supplies. If passed, the bill would reinstate additional payment made to physicians for IVIG administration in the hospital outpatient and physician office settings. It would also provide reimbursement for IVIG administration services given in the home setting. Previously, the additional reimbursement was not eligible to providers in the home setting.



CMS Finalizes Rule to Implement ICD-10 Coding System

In the US, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes are used to identify patient diagnoses in nearly all settings of care, and ICD-9-CM procedure codes are used primarily to report hospital inpatient services. The ICD-9-CM system has been in use for almost 30 years. As medical treatments and technologies continue to advance, it is important to have a coding system in place that is sufficiently

ICD-10-PCS Procedure Codes	ICD-10-CM Diagnosis Codes
<ul style="list-style-type: none"> • 7 Digits • Each either alpha or numeric (alpha digits are not case sensitive and letters O and I are not used to avoid confusion with numbers 0 and 1) <p>Examples:</p> <ul style="list-style-type: none"> • 30230R1: Transfusion of Nonautologous Platelets into Peripheral Vein, Open Approach • 30230H0: Transfusion of Autologous Whole Blood into Peripheral Vein, Open Approach 	<ul style="list-style-type: none"> • 3-7 Digits • Digit 1 is alpha • Digits 2&3 are numeric, and • Digits 4-7 are alpha or numeric (alpha digits are not case sensitive) <p>Examples:</p> <ul style="list-style-type: none"> • D500: Iron deficiency anemia secondary to blood loss (chronic) • D6101: Constitutional (pure) red blood cell aplasia

detailed to capture current health care information accurately and that also leaves room for growth. CMS has determined that the current system lacks specificity and detail that is necessary in a health care system that has advanced significantly since the time ICD-9-CM was developed.

On January 16, 2009, CMS issued a final rule that replaces the ICD-9-CM code set with the more robust and descriptive ICD-10 Clinical Modification (CM) and Procedure Coding System (PCS) code sets. The ICD-10 code

set was developed in 1978 and is currently used in several European countries. The compliance date for implementation of ICD-10 CM and PCS is October 1, 2013 for all Health Insurance Portability and Accountability Act (HIPAA) covered entities.

While the ICD-9-CM code set includes both diagnosis and procedure codes, ICD-10 is split into two code sets, diagnosis and procedure codes: ICD-10-CM for diagnosis and ICD-10-PCS for procedures.

The ICD-10-CM coding system includes about 68,000 available diagnosis codes, as opposed to the 13,000 current codes in ICD-9-CM. ICD-10-CM has a

similar format to ICD-9-CM but offers significantly more detail within each code.

ICD-10-PCS includes about 87,000 procedure codes, as opposed to the 3,000 current codes in ICD-9-CM. Descriptions differentiate body parts, surgical approaches, and devices used in procedures. Each character in a code has a specific meaning, which may change depending on the type of procedure. The table below summarizes the structure and key components of the ICD-10-CM and PCS coding system.

ICD-10: Next Steps

- ✓ Obtain a senior management level “sponsor” for ICD-10 related activities.
- ✓ Create ICD-10 awareness throughout the organization. This includes educating senior management, information system personnel, clinical department managers, and medical staff on the upcoming transition to ICD-10.
- ✓ Work with senior management regarding the potential budgetary, administrative and operational implications of making the transition to ICD-10.
- ✓ Conduct a detailed assessment of staff education needs.
- ✓ Identify key players in your organization who should be part of your ICD-10 implementation team.
- ✓ Identify an ICD-10 team leader.
- ✓ Assess the impact of the change to the new coding systems and identify key tasks and objectives. Major tasks may include creating an implementation planning team; identifying and budgeting for required information system changes; and assessing and budgeting clinician and code set user education.
- ✓ Assess the impact of coding change related to strategic goals around electronic health records and other information technology plans on quality and performance.
- ✓ Develop an inventory of existing databases and systems likely to be affected by a transition to ICD-10-CM and ICD-10-PCS.
- ✓ Determine which systems use homegrown, proprietary or custom-made software.
- ✓ Consult with your existing software vendors to determine their awareness of ICD-10 and their plans for upgrades.
- ✓ Determine whether your current contractual agreements with vendors will cover a change to ICD-10.
- ✓ Consider ICD-10 readiness in any future system improvements, such as plans for an electronic health record.
- ✓ Start working with your medical staff to improve medical record documentation. There are tangible benefits that can be gained, even with ICD-9-CM.
- ✓ Watch for upcoming AHA educational sessions on ICD-10 by visiting the AHA ICD-10 Resource Center (see the link provided above).

Tips for Hospitals to get ICD-10-Ready

The ICD-10 guidance has significant implications for all HIPAA-covered entities and health care professionals, who will play a large role in transitioning to the new coding system. The conversion to ICD-10 will require significant budgetary, training, and information system planning in order to ensure a successful transition.

The American Hospital Association (AHA) has issued a checklist intended to assist hospitals in preparing for ICD-10. The checklist is included in the table below, and can be accessed at:

http://www.ahacentraloffice.com/ahacentraloffice_app/ICD-10/ICD-10.jsp