Analysis of Final Rule for FY 2008 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year (FY) 2008 revisions to the Medicare hospital inpatient prospective payment system (IPPS) was published in the August 22, 2007 issue of the *Federal Register*. This rule becomes effective on October 1, 2007. This analysis covers highlights of the rule that are of particular interest to health information management (HIM) professionals. Changes that were proposed in the proposed rule but not adopted in the final rule are not addressed. The final rule can be reviewed in its entirety by downloading it from this link: http://www.access.gpo.gov/su_docs/fedreg/a070822c.html.

CHANGES TO DRG CLASSIFICATIONS AND RELATIVE WEIGHTS

REFINEMENT OF DRGS BASED ON SEVERITY OF ILLNESS

The Centers for Medicare & Medicaid Services (CMS) are focusing their efforts in FY08 on making significant reforms to the IPPS consistent with the recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its "Report to the Congress, Physician-Owned Specialty Hospitals" in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking into account severity of illness and applying hospital-specific relative value (HSRV) weights to DRGs. They began the reform process by adopting cost-based weights over a 3-year transition period beginning in FY07 and making interim changes to the DRG system for FY07 that involved creating 20 new DRGs and modifying 32 others across 13 different clinical areas.

At the time of the FY08 final rule, the RAND Corporation had completed its evaluation of alternative severity-adjusted systems, including the Medicare Severity DRG (MS-DRG) system. RAND's findings demonstrate that MS-DRGs explain 43 percent of variation in costs (a 9.1 percent improvement over the current DRGs). RAND found that the MS-DRGs are an improvement over the current CMS DRGs and compare favorably to the alternative DRG system on some criteria and not as well on others. RAND reported that the explanatory power of the MS-DRGs is lower than all but one of the alternative severity-adjusted DRG systems they analyzed.

Although CMS acknowledged that RAND's findings related to the explanatory power of MS-DRGs in certain Major Diagnostic Categories (MDCs) are of concern, they believe the MS-DRGs are still an improvement over the current DRGs (referred to as "CMS DRGs) and have significant advantages over the other DRG systems that were evaluated. MS-DRGs are more up-to-date because of CMS' review of secondary diagnoses and classification into major complications/comorbidities (MCCs) and complications/comorbidities (CCs). MS-DRGs are understandable, available in the public domain, and will have fewer transition issues than the other alternative systems evaluated by RAND. Since MS-DRGs are a modification of the current CMS DRGs, they allow for updates and maintenance to continue using the same process as under the current CMS DRGs. CMS believes the MS-DRGs represent a substantial improvement over the current CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

CMS believes it is appropriate to adopt the MS-DRG system for the Medicare IPPS in FY08. While there will be an opportunity for the public to comment on RAND's findings, CMS expects to permanently adopt the MS-DRGs for the IPPS. They do not think it is likely that there will be persuasive public comments suggesting that one of the alternative DRG systems evaluated by RAND is clearly superior. In CMS' view, none of the systems appears to be clearly superior or inferior to the other systems based on the criteria RAND used for the evaluation. CMS plans to use RAND's report to continue to examine ways to improve and refine the Medicare IPPS and expects that any future refinements will be based on the MS-DRGs. **As final policy for FY08, CMS is adopting the MS-DRGs as the new DRG classification system for the IPPS.**

RAND's reports describing their evaluation of severity-adjusted DRG systems, including an interim report, addendum to the interim report, and a final report, can be accessed from the CMS web site (see link under Resources at the end of this document). The addendum to the interim report contains RAND's analysis of the MS-DRG system.

Revisions to the CC List (72FR47153)

CMS' efforts to better recognize severity of illness began with a comprehensive review of the CC list. As a result of the changes that have occurred during the 22 years since the implementation of the IPPS, the CC list as currently defined has lost much of its capacity to discriminate hospital resource use. The need for a revised CC list prompted a reexamination of the secondary diagnoses that qualify as a CC. Using a combination of mathematical data and the judgment of CMS' medical officers, a condition was included on the revised CC list if it could demonstrate that its presence would lead to substantially increased hospital resource use.

As part of the process of revising the CC list, CMS removed chronic diseases without a significant acute manifestation, as long as there are ICD-9-CM codes available that allow the acute manifestation of the disease to be coded separately. Exceptions were made for diagnosis codes that indicate a chronic disease in which the underlying illness has reached an advanced stage or is associated with systemic physiologic decompensation

and debility. The revised CC list is essentially comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases, and chronic diseases associated with extensive debility.

The revisions to the CC list resulted in 40.34 percent of patients having at least 1 CC present, compared to 77.66 percent previously. The revised CC list increases the difference in average charges between patients with and without a CC by 56 percent ($15,236 vs. $9,743).

Development of the MS-DRGs (72FR47155)

The MS-DRGs represent a comprehensive approach to applying a severity of illness stratification for Medicare patients throughout the DRGs. They maintain the significant advancements in identifying medical technology made to the DRGs in past years. At the same time, they greatly improve CMS' ability to identify groups of patients with varying levels of severity using secondary diagnoses. They also improve CMS' ability to assign patients to different DRG severity levels based on resource use that is independent of the patient's secondary diagnoses (referred to as "complexity" in the final rule).

The MS-DRG system modifies the current CMS DRGs by collapsing any paired DRGs (DRGs distinguished by the presence or absence of CCs and/or age) into base DRGs and then splits the base DRGs into MCC/CC severity levels. So, the first step in the process of creating MS-DRGs was the consolidation of existing CMS DRGs into new base MS-DRGs. The end result of the consolidation was 335 base DRGs.

Three different levels of CC severity were established into which diagnosis codes were subdivided: Major CCs (MCCs), CCs, and non-CCs. MCCs reflect the highest level of severity and non-CCs reflect the lowest level. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use and, therefore, they do not impact DRG assignment. The categorization of diagnoses as an MCC, CC, or non-CC was accomplished using an iterative approach in which each diagnosis was evaluated to determine the extent to which its presence as a secondary diagnosis resulted in increased hospital resource use.

To determine whether each secondary diagnosis should be an MCC, CC, or non-CC, the revised CC list was used in combination with the categorization under the AP-DRG and APR-DRG systems. A diagnosis was designated as an MCC if it was a CC in the revised CC list and an AP-DRG major CC and an APR-DRG default severity level 3 (major) or 4 (extensive). A diagnosis was designated as a non-CC if it was a non-CC in the revised CC list and an AP-DRG non-CC and an APR-DRG default severity level 1 (minor). Any diagnoses that did not meet either of these criteria were designated as a CC.

The only exception to this approach was for diagnoses related to newborns, maternity, and congenital anomalies. These diagnoses are very low volume in the Medicare population and were not reviewed for purposes of creating the revised CC list. The APR-DRGs were used to categorize these diagnoses. For newborn, obstetric, and congenital

anomaly diagnoses, the APR-DRG default severity level 3 and 4 diagnoses were designated as an MCC, the APR-DRG default severity level 2 diagnoses were designated as a CC, and the APR-DRG default severity level 1 diagnoses were designated as a non-CC.

Classification of each diagnosis as an MCC, CC, or non-CC was further modified by assessing the impact of each diagnosis on resource use. In determining the CC subclass assigned to a diagnosis, imprecise codes were, in general, not assigned to the MCC or CC subclass. Congenital anomaly codes were not classified as an MCC or CC because there would be other reported diagnosis codes that better describe the exact nature of the condition being treated.

Diagnoses that were closely associated with patient mortality were assigned different CC subclasses, depending on whether the patient lived or died. These diagnoses are:

- 427.41, Ventricular fibrillation
- 427.5, Cardiac arrest
- 785.51, Cardiogenic shock
- 785.59, Other shock without mention of trauma
- 799.1, Respiratory arrest.

These diagnoses are assigned an MCC subclass for patients who lived and a non-CC subclass for patients who died.

For some secondary diagnoses assigned to the CC subclass, CMS' medical advisors identified certain clinical situations in which the diagnosis should not be considered a CC. In such clinical situations, the CC exclusion list was used to exclude the secondary diagnosis from consideration in determining the CC subgroup. For example, primary cardiomyopathy (a CC) will be treated as a non-CC when the principal diagnosis is congestive heart failure.

In designating an MS-DRG as one that will be subdivided into subgroups based on the presence of a CC or MCC, a set of criteria were developed to facilitate CMS' decision-making process. In order to warrant creation of a CC or MCC subgroup within a base DRG, the subgroup had to meet all of the following 5 criteria:

- A reduction in variance of charges of at least 3 percent
- At least 5 percent of patients in the MS-DRG fall within the CC or MCC subgroup
- At least 500 cases are in the CC or MCC subgroup
- There is at least a 20 percent difference in average charges between subgroups, and
- There is a $4,000 difference in average charges between subgroups.

Based on a methodology that applied these criteria, a base MS-DRG may be subdivided according to 3 alternatives (rather than the current "with CC" and "without CC" split):

- DRGs with 3 subgroups (MCC, CC, non-CC)

- DRGs with 2 subgroups consisting of an MCC subgroup but with the CC and non-CC subgroups combined ("with MCC," "without MCC")
- DRGs with 2 subgroups consisting of a non-CC subgroup but with the CC and MCC subgroups combined ("with CC/MCC," "without CC/MCC").

This process resulted in the creation of 745 MS-DRGs.

Under the current CMS DRGs, 78 percent of cases are assigned to the highest severity levels (CC) and the remaining 22 percent are assigned to the lowest severity level (non-CC). Applying the 3 severity subclasses to FY06 data would result in approximately 22 percent of patients being assigned to the severity subgroup with the highest level of severity (MCC), 41 percent being assigned to the lowest severity subclass (non-CC), and the remaining 37 percent being assigned to the middle severity subclass (CC).

Several commenters (including AHIMA) opposed the re-use of the current CMS DRG numbers in the MS-DRG system and suggested a 4-digit numbering scheme be used instead. CMS responded that they agree moving to a 4-character numbering scheme would be beneficial. They have already developed an internal version with 4 characters, with the 4th character indicating the severity level. Systems restrictions prevent CMS from using this 4-character numbering system in Medicare's data systems at this time. However, they will continue to evaluate the possibility of moving to such a numbering system in the future.

<u>Changes to Case-Mix Index (CMI) from the MS-DRGs</u> (72FR47175)

CMS is concerned that the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current CMS DRGs may result in a case being assigned to a higher paid DRG under the proposed MS-DRGs. Thus, more accurate and complete documentation and coding may occur because it will result in higher payments under the MS-DRG system.

CMS believes that adoption of MS-DRGs could create a risk of increased aggregate levels of payment as a result of increased documentation and coding. The IPPS standardized amount will be reduced by 1.2 percent for FY08 to account for the effect of changes in coding or classification of discharges that do not reflect real changes in case mix. Based on current projections, an adjustment of -1.8 percent will be applied each year to the IPPS standardized amounts for FYs 2009 and 2010. CMS will compare the actual increase in case mix due to documentation and coding to their projection once they have actual data to revise the estimate and the adjustment to the standardized amounts. They will consider revising the planned adjustment for FY09 and FY10 if information in the Medicare billing data suggests that their projections are either too high or low compared to actual experience.

Effect of the MS-DRGs on the Postacute Care Transfer Policy (72FR47186)

CMS' policy for making a DRG subject to the postacute care transfer policy under the MS-DRGs is unchanged other than to make it conform to the new DRG system.

Under both the CMS DRGs and MS-DRGs, there are 2 criteria for making a DRG subject to the postacute care transfer policy:

- The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs, and
- The proportion of short-stay discharges to postacute care to total discharges in the DRG must equal or exceed the 55th percentile for all DRGs.

The 55th percentile thresholds had to be recalculated in order to determine which MS-DRGs would be subject to the postacute care transfer policy to conform the existing policy to the new DRG system.

An MS-DRG will be subject to the postacute care transfer policy if it is a set of DRGs subdivided based on MCCs, CCs, and non-CCs where one of the DRGs in the set meets the numerical criteria specified above. So, for FY08, 273 out of 745 MS-DRGs are subject to the postacute care transfer policy (36 percent).

Hospital-Acquired Conditions, Including Infections (72FR47200)

Section 5001(c) of Pub. L. 109-171 requires the Secretary to select, by October 1, 2007, at least two conditions that are (a) 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) could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. In other words, the case will be paid as though the secondary diagnosis was not present.

Reduced reimbursement in the form of a lower-paying DRG for one of the selected hospital-acquired conditions will only occur when the selected conditions are the only MCCs and CCs present on the claim. If the patient has other secondary diagnoses that an MCC or CC, the case will continue to be assigned to the higher-paying MCC or CC DRG and there will be no savings to Medicare from that case. CMS believes the provision pertaining to hospital-acquired conditions will apply in a small minority of cases because it is rare that one of the selected conditions will be the only MCC or CC present on the claim.

CMS worked with public health and infectious disease experts from the Centers for Disease Control and Prevention (CDC) to identify a list of hospital-acquired conditions, including infections. The present on admission (POA) indicator will be used to determine which of the selected conditions developed during a hospital stay.

CMS stated that they appreciate all of the comments they received on hospital-acquired conditions and look forward to continued input as they plan to implement the provision regarding hospital-acquired conditions. **They continue to work on further refinements which will be included in next year's proposed rule and welcome industry suggestions.**

Table 1 below contains the list of hospital-acquired conditions CMS selected in the FY08 final rule. These conditions will be made subject to the provision (regarding impact on MS-DRG assignment) beginning on October 1, 2008 (FY09).

Table 1. Hospital-Acquired Conditions

Condition	ICD-9-CM Codes Identified in Final Rule
Serious preventable event – Object left in during surgery	998.4
Serious preventable event – Air embolism	999.1
Serious preventable event – Blood incompatibility	999.6
Catheter-associated urinary tract infection	996.64; codes representing a specific type of urinary tract infection when reported with code 996.64 (codes identified in the final rule are 112.2, 590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 590.9, 595.0, 595.3, 595.4, 595.81, 595.89, 595.9, 597.0, 597.80, 599.0)
Pressure ulcers	707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09
Vascular catheter-associated infections	999.31; infection codes reported with code 999.31 (specific codes not identified in final rule)
Surgical site infection – Mediastinitis after coronary artery bypass surgery	519.2 + a coronary artery bypass procedure code (36.10-36.19)
Hospital-acquired injuries – Fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes	*ICD-9-CM code ranges:* 800-829, 830-839, 850-854, 925-929, 940-949, 991-994

For hospital-acquired injuries, CMS examined the use of a combination of external cause of injury codes and the specific injury to identify patients who had preventable injuries that occurred in the hospital. They concluded that this approach is too complicated. Instead, they focused on simply identifying injuries that should not occur during a hospitalization. CMS reviewed diagnosis codes contained in the Injury and Poisoning chapter of ICD-9-CM and attempted to develop a list of codes that could identify potential adverse events that may or may not have been the result of a fall occurring in the hospital setting. **They welcome public comments on additions and deletions to their injury list (noted below) as well as their findings on the use of a combination of**

external cause of injury codes and injury codes to identify patients that acquired an injury in the hospital due to a fall.

Changes to Specific DRG Classifications

Pre-MDCs: Intestinal Transplantation (72FR47218)

All intestinal transplant cases have been moved to MS-DRG 005. As a result, this MS-DRG has been redefined as "Liver transplant with MCC or Intestinal Transplant." The presence of a liver transplant with an MCC or an intestinal transplant would assign a case to this MS-DRG. Lower-weighted MS-DRG 006 would contain all liver transplants without an MCC.

MDC 1 (Diseases and Disorders of the Nervous System): Implantable Neurostimulators (72FR47219)

The codes for central and chronic pain syndrome and chronic pain (ICD-9-CM codes 338.0, 338.21 through 338.29, and 338.4) have been moved from MDC 23 (Factors Influencing Health Status and Other Contacts within Health Services) to MDC 1 (Diseases and Disorders of the Nervous System) when they are assigned as the principal diagnosis. These pain codes will likely be a common principal diagnosis for patients who receive a neurostimulator.

MDC 1: Intracranial Stents (72FR47220)

Procedure code 00.62, Percutaneous angioplasty or atherectomy of intracranial vessel(s), has been assigned to MS-DRGs 025, 026, and 027 (Craniotomy and Endovascular Intracranial Procedures, split by the presence of an MCC, CC, or no CC/MCC) and MS-DRGs 023 and 024 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis, split by the presence or absence of an MCC). Code 00.62 was previously assigned to the CMS DRGs for extracranial procedures. CMS believes there is clinical consistency between code 00.62 and codes 39.72, 39.74, and 39.79 (endovascular repair of vessels) which were already assigned to the craniotomy DRGs.

Since Medicare only covers an intracranial percutaneous angioplasty when performed in conjunction with insertion of a stent, code 00.62 must be accompanied by code 00.65 (Percutaneous insertion of intracranial vascular stent(s)) in order for the procedure to be covered by Medicare. If code 00.65 is not reported on the claim, the case would fail the Non-Covered Procedure MCE edit and the claim would be denied.

<u>MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat): Cochlear Implants</u> (72FR47221)

Cochlear implant cases have been assigned to MS-DRG 129, which is defined as "Major Head and Neck Procedures with CC or MCC or Major Device." The presence of a major head and neck procedure with a CC or MCC or major device would assign the case to the higher severity level within the set of MS-DRGs for Major Head and Neck Procedures.

<u>MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Knee Replacements</u> (72FR47222)

Codes 00.83 (Revision of knee replacement, patellar component) and 00.84 (Revision of total knee replacement, tibial insert (liner)) have been moved from MS-DRGs 466, 467, and 468 (Revision of Hip or Knee Replacement with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 485, 486, 487 and 489 (Knee Procedures split on the basis of an infection as the principal diagnosis and the presence or absence of a CC or MCC). These procedures have significantly lower charges than other cases in MS-DRGs 466, 467, and 468.

<u>MDC 8: Spinal Fusions</u> (72FR47226)

Cases where 9 or more vertebrae have been fused (code 81.64) have been moved from MS-DRGs 459 and 460 (Spinal Fusion except Cervical with MCC and without MCC, respectively) to MS-DRGs 456 through 458 because they have significantly higher average charges than other cases in MS-DRGs 459 and 460.

CMS' analysis also demonstrated that spinal fusion cases with a principal diagnosis of tuberculosis or osteomyelitis have higher average charges than other cases in MS-DRGs 459 and 460. These cases will also be moved to MS-DRGs 456-458. Tuberculosis of vertebral column and osteomyelitis of other specified sites have been added to the list of principal diagnoses for MS-DRGs 456-458.

The MS-DRG titles would be revised to reflect the above-mentioned changes:

- MS-DRG 456: Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or 9+ Fusions with MCC
- MS-DRG 457: Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or 9+ Fusions with CC
- MS-DRG 458: Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or 9+ Fusions without CC/MCC.

<u>MDC 8: Spinal Disc Devices</u> (72FR47229)

Procedure codes 84.59 (Insertion of other spinal devices), 84.62 (Insertion of total spinal disc prosthesis, cervical), 84.65 (Insertion of total spinal disc prosthesis, lumbosacral), 84.80 (Insertion or replacement of interspinous process device(s)), 84.82 (Insertion or replacement of pedicle-based dynamic stabilization device(s)), and 84.84 (Insertion or

replacement of facet replacement device(s)) have been assigned to MS-DRG 490, which has been redefined as "Back and Neck Procedures Except Spinal Fusion with CC or MCC or Disc Device."

Medicare Code Editor (MCE) Changes: Non-Covered Procedure Edit (72FR47232)

A change has been made to the Non-Covered Procedure edit to identify code 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessel(s)) as a non-covered procedure except when it is accompanied by code 00.65 (Percutaneous insertion of intracranial vascular stent(s)).

MCE Changes: Non-Specific Principal Diagnosis and Non-Specific O.R. Procedure Edits (72FR27233)

CMS stated that the edits for non-specific principal diagnosis and non-specific operating room (O.R.) procedure were created with the intention of encouraging hospitals to code as specifically as possible. It was never CMS' intention that these edits would be used to deny/reject or return to provider those claims submitted with non-specific codes. CMS has found that these two edits are being misunderstood, and claims were erroneously being denied, rejected, or returned. As part of the FY08 rulemaking process, CMS identified a list of specific ICD-9-CM codes that have been removed from these two edits. This list can be found on pages 47233-47238 of the final rule.

MCE Changes: Limited Coverage Edit (72FR47238)

CMS has added the following procedure codes to the existing list of limited coverage procedures to ensure that Medicare covers only those organ transplants performed in Medicare approved facilities:

- 55.69, Other kidney transplantation
- 52.80, Pancreatic transplant, not otherwise specified
- 52.82, Homotransplant of pancreas

MCE Changes: Revision to Part 1, Pancreas Transplant Edit A (72FR47238)

MCE edit A stated that codes 52.80 and 52.82 are identified as non-covered procedures except when either of these codes is combined with certain procedure and diagnosis codes. Effective for services on or after April 26, 2006, a National Coverage Determination was published stating that pancreas transplants are reasonable and necessary for Medicare beneficiaries in facilities that are Medicare-approved for kidney transplantation. Patients must have a diagnosis of Type 1 diabetes mellitus.

Edit A has been removed from the MCE. Procedure codes 52.80 and 52.82 could still trigger a limited coverage edit (see earlier discussion regarding limited coverage edits).

<u>CC Exclusions List</u> (72FR47239)

Limited revisions to the CC Exclusion List have been made to take into account the October 1, 2007 changes to the ICD-9-CM diagnosis coding system. The CC Exclusion List is also being updated to reflect the exclusion of a few codes from being an MCC under the MS-DRG system.

A complete, updated MCC, CC, and Non-CC Exclusions List is available on the CMS web site at: http:/www.cms.hhs.gov/AcuteInpatientPPS. Beginning with discharges on or after October 1, 2007, the indented diagnoses will not be recognized as valid CCs for the asterisked principal diagnosis.

<u>Devices that are Replaced Without Cost or Where Credit for a Replaced Device is Furnished to the Hospital</u> (72FR47246)

CMS believes that Medicare should not pay hospitals for the full cost of replacement of a device if the hospital is receiving a partial or full credit, either due to a recall or service during the warranty period. Payment of the full IPPS payment amount in cases in which the device was replaced under warranty or in which there was a full or partial credit for the price of the recalled or failed device effectively results in Medicare payment for a noncovered item.

In certain instances, Medicare will reduce the amount of the IPPS payment when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device. CMS does not believe this policy should apply to all DRGs and all situations in which a device is replaced without cost to the hospital for the device or with full or partial credit for the removed device. In many cases, the cost of the device is a relatively modest part of the IPPS payment. In other situations, the amount of the credit will also be nominal. Therefore, this policy will only be applied to those MS-DRGs where the implantation of the device determines the base DRG assignment and situations where the hospital received a credit equal to 50 percent or more of the cost of the device.

Condition codes 49 and 50 (established by the National Uniform Billing Committee) will be used to identify claims where a provider has received a device or product without cost. Hospitals must report these condition codes on any claim for IPPS services that includes a replacement device or product for which they received full or partial credit. The specific ICD-9-CM code for the procedure performed should also be reported. The hospital should also provide invoices or other information indicating its normal cost of the device and the amount of credit it received.

Hospitals have the option of either submitting the claim immediately without condition code 49 and a claim adjustment with condition code 49 at a later date once the credit determination is made or holding the claim until a determination is made on the level of the credit.

<u>Other MS-DRG Issues Raised in Public Comments: Gliadel® Wafer</u> (72FR47252)

CMS had initially proposed classifying implantation of the Gliadel® Wafer to MS-DRGs 023 and 024 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC and without MCC, respectively). Based on public comments, CMS decided to assign all cases of Gliadel Wafer implantation to MS-DRG 023 and to re-title this MS-DRG "Craniotomy with Major Device Implant o Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemo Agent Implant."

<u>Other MS-DRG Issues Raised in Public Comments: Peripheral and Spinal Neurostimulators</u> (72FR47253)

CMS has decided to assign the full system spinal cord nonrechargeable and rechargeable neurostimulator cases in MS-DRG 30 (Spinal Procedures without CC) to MS-DRG 029. MS-DRG 029 has been defined as "Spinal Procedures with CC or Neurostimulator." ICD-9-CM procedure codes 03.93 (Implantation or replacement of spinal neurostimulator lead(s)) and 86.94, 86.95, 86.97, or 86.98 (codes for implantation of neurostimulator pulse generator) must be reported in order for the spinal neurostimulator cases to be assigned to MS-DRG 029.

The full system peripheral nonrechargeable and rechargeable neurostimulator cases in MS-DRG 042 (Peripheral and Cranial Nerve and Other Nervous System Procedures without CC) have been assigned to MS-DRG 041. MS-DRG 041 has been defined as "Peripheral and Cranial Nerve and Other Nervous System Procedures with CC or Neurostimulator." ICD-9-CM procedure codes 04.92 (Implantation or replacement of peripheral neurostimulator lead(s)) and 86.94, 86.95, 86.97, or 86.98 must be reported in order for the peripheral neurostimulator cases to be assigned to MS-DRG 041.

The full system spinal cord nonrechargeable and rechargeable neurostimulator cases in MS-DRG 491 have been assigned to MS-DRG 490. MS-DRG 490 has been defined as "Back and Neck Procedures except Spinal Fusion with CC/MCC or Disc Devices or Neurostimulator." ICD-9-CM procedure codes 03.93 and 86.94, 86.95, 96.97, or 86.98 must be reported in order for the spinal neurostimulator cases to be assigned to MS-DRG 490.

<u>Other MS-DRG Issues Raised in Public Comments: Coronary Artery Stents</u> (72FR47259)

As a result of public comments, CMS has decided that claims containing code 00.66 (Percutaneous transluminal coronary angioplasty or coronary atherectomy) and code 36.07 (Insertion of drug-eluting coronary artery stent(s)) and code 00.43 (Procedure on four or more vessels) or code 00.48 (Insertion of four or more vascular stents) will be assigned to MS-DRG 246. Commenters had suggested that procedures involving multiple coronary vessels or stents should be assigned to the higher-weighted MS-DRG in the series. Claims containing code 00.66 and code 36.06 (Insertion of non-drug-eluting

coronary artery stent(s)) and code 00.43 or code 00.48 have been assigned to MS-DRG 248. The title of MS-DRG 246 has been changed to "Percutaneous Cardiovascular Procedures with Drug-Eluting Stent(s) with MCC or 4 or more Vessels/Stents." The title of MS-DRG 248 has been changed to "Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent(s) with MCC or 4 or more Vessels/Stents."

Other MS-DRG Issues Raised in Public Comments: Endovascular Repair of Aortic and Thoracic Aneurysms (72FR47260)

CMS looked at data to review the differences between endovascular graft repair of abdominal aortic aneurysm (code 39.71) and endovascular graft repair of thoracic aortic aneurysm (code 39.73). Based on this review, they have assigned code 39.73 to MS-DRG 237. This MS-DRG has been re-titled "Major Cardiovascular Procedures with CC or Thoracic Aortic Aneurysm Repair."

Other MS-DRG Issues Raised in Public Comments: High Dose Interleukin-2 (IL-2) (72FR47262)

Procedure code 00.15 (High-dose infusion Interleukin-2) has been assigned to MS-DRGs 837 (Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC) and 838 (Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent).

Note: All changes that were made to the MS-DRGs as a result of public comments received on the FY08 proposed rule are listed in a summary chart on page 47264 of the final rule.

Add-On Payments for New Services and Technologies

Endovascular Graft Repair of the Thoracic Aorta (72FR47303)

Because the technology no longer meets the newness criterion, CMS is discontinuing new technology add-on payments for GORE TAG for FY08.

Restore® Rechargeable Implantable Neurostimulator (72FR47303)

Because the technology no longer meets the newness criterion, CMS is discontinuing new technology add-on payments for Restore® Rechargeable Implantable Neurostimulator for FY08.

X STOP Interspinous Process Decompression System (72FR47304)

CMS is discontinuing new technology add-on payments for the X STOP device. It no longer meets the cost threshold. Also, the high costs for cases using the X STOP device that necessitated an add-on payment under the CMS DRGs is no longer necessary under

MS-DRGs because of the higher payment that would be made under MS-DRG 490 (Back and Neck Procedures except Spinal Fusion with CC/MCC or Disc Devices).

Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

Reporting of Hospital Quality Data for Annual Hospital Payment Update (72FR47345)

The Deficit Reduction Act of 2005 established the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program to build upon the Hospital Quality Initiative. Hospitals are now required to report on an additional 6 measures, for a total of 27, for FY 2008 as outlined in the CY 2007 OPPS final rule to ensure there was enough time for hospitals to prepare for upcoming changes. If a hospital chooses to withdraw from the program, it will receive a 2.0 percentage point reduction in its annual payment update.

For new quality measures FY 2009and beyond, CMS is adopting 1 of the 5 proposed measures with the anticipation of adopting an additional 3 measures with the CY 2008 OPPS final rule assuming that these measures have received National Quality Forum (NQF) endorsement. CMS had proposed in the rule possible measures and measure sets for the RHQDAPU program for FY 2009 and subsequent years. Based upon the comments received, CMS has chosen not to adopt any of the recommended measures and measure sets for FY 2009 but will consider them for future years.

CMS requested suggestions and comments regarding the development of a process for retiring or replacing measures in the RHQDAPU program to accommodate changes and the evolution of the program and clinical advancements. Based upon the feedback received during the comment period, CMS indicates that they are continuing to consider ways to develop a process for retiring and/or replacing measures for the future.

CMS has indicated that due to time constraints, they will not apply chart validation requirements to the FY 2008 update to 3 measures that have been included in the measure set. Starting in July 2007, CMS requested that hospital/survey vendors to correct any problems that are found during the data collection process and to provide follow up documentation of corrections that were conducted. Should the HCAHPS determine that the hospital has not made the corrections; CMS may determine whether or not the organization is not meeting the requirements for the RHQDAPU program. For the FY 2009 period, all FY 2008 requirements would apply, with the exception of the following modifications. CMS plans to modify the validation requirements to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges. The list of validate measures in the FY 2009 update starting with 4th quarter CY 2006 discharges. CMS also plans to discontinue the two step process to determine if the hospital is submitting valid data.

To address appeal procedures for submission of data to the RHQDAPU program, CMS indicated that for FY 2008 hospitals must submit their request for consideration on or before November 1, 2008. CMS is also planning to establish additional procedural rules that will govern RHQDAPU program considerations which will be posted in the Quality Net Exchange website during final rule publication.

CMS has finalized its proposed rule regarding new hospital participation in the RHQDAPU program. For FY 2008 and subsequent years for new hospitals, fiscal intermediaries will continue to provide information on the new hospital to the QIO in the state which the hospital is located, as soon as possible, so that the QIO can ensure the hospital is meeting its data reporting requirements. For a new hospital that receives a provider number on or after October 1 of each year (beginning with October 1, 2007) CMS is requiring that the hospital will be required to report data for measures beginning with the first day of the quarter following the date the hospital registered to participate in the RHQDAPU program.

For questions concerning this summary or the FY 2008 IPPS final rule, contact Sue Bowman, AHIMA's Director of Coding Policy and Compliance, at sue.bowman@ahima.org.

Resources

The final rule regarding the fiscal year 2008 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 22, 2007 issue of the *Federal Register* located at: http://www.access.gpo.gov/su_docs/fedreg/a070822c.html.

AHIMA's letter to CMS regarding the proposed rule for fiscal year 2008 revisions to the Medicare hospital inpatient prospective payment system can be found on the Policy and Government Relations section of the AHIMA web site: http://www.ahima.org/dc/.

RAND's report on their evaluation of severity-adjusted DRG systems can be accessed from this link on the CMS web site:
http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?itemID=CMS1197292.