CDI/Coder Companion:
MS-DRGs and the IPPS in Fiscal Year 2017

© 2014-2016

Priority. Clarity. Integrity.

nSIGHT-DRIVEN

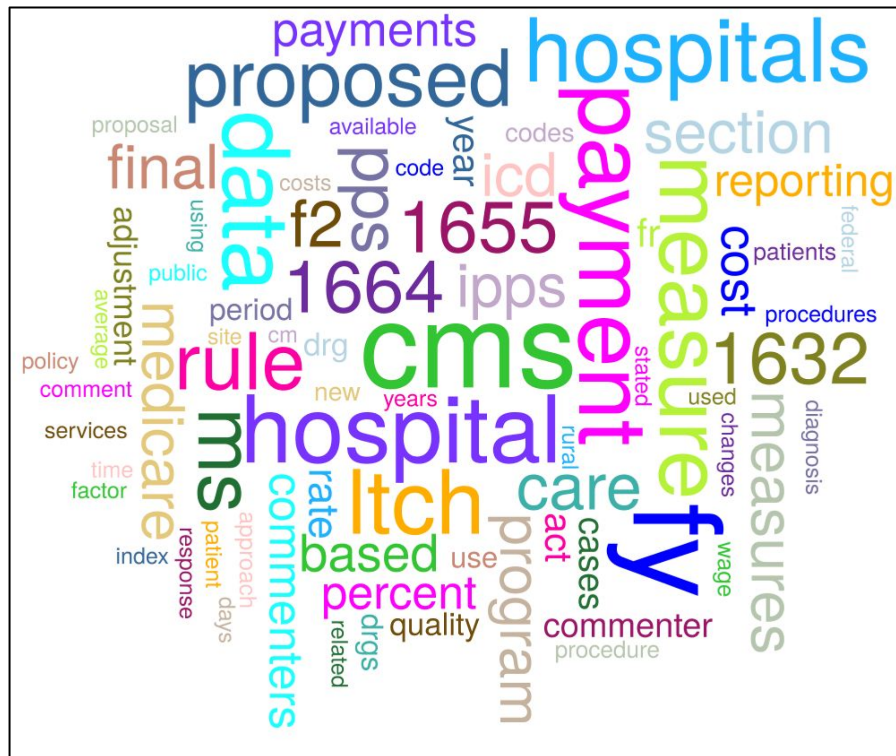
RECORDSONE

© 2014-2016

Voyant WebNLP

This corpus has 1 document with 669,482 total words and 17,692 unique word forms.

Most **frequent words** in the corpus: fy (5849); cms (4218); hospital (3700); ltch (3595); data (3535)



RECORDSONE

© 2014-2016

MS-DRG Documentation and Coding Adjustment

For FY 2017, we are making an additional -1.5 percent recoupment adjustment to the standardized amount.

Two Midnight Policy Adjustment

In this final rule, we are making a permanent adjustment of (1/0.998) to the standardized amount, the hospital-specific payment rates, and the national capital Federal rate using our authority under sections 1886(d)(5)(I)(i) and 1886(g) of the Act to prospectively remove the 0.2 percent reduction to the rate put in place in FY 2014 to offset the estimated increase in IPPS expenditures as a result of the 2-midnight policy.

RECORDSONE

© 2014-2016

Reduction of Hospital Payments for Excess Readmissions

In this final rule, to align with other quality reporting programs and allow us to post data as soon as possible, we are clarifying our public reporting policy so that excess readmission rates will be posted to the Hospital Compare Web site as soon as feasible following the preview period, and we are revising the methodology to include the addition of the CABG applicable condition in the calculation of the readmissions payment adjustment for FY 2017.

Hospital VBP Program

Updating, removing, adopting measures

RECORDSONE

© 2014-2016

Hospital-Acquired Condition (HAC) Reduction Program

In this final rule, we are promulgating the following HAC Reduction Program policies:

(1) establishing NHSN CDC HAI data submission requirements for newly opened hospitals;
(2) clarifying data requirements for Domain 1 scoring;
(3) establishing performance periods for the FY 2018 and FY 2019 HAC Reduction Programs, including revising our regulations to accommodate variable timeframes;
(4) adopting the refined PSI 90: Patient Safety and Adverse Events Composite (NQF #0531); and
(5) changing the program scoring methodology from the current decile-based scoring to a continuous scoring methodology.

Hospital Inpatient Quality Reporting (IQR) Program

- *removing 15 measures for the FY 2019 payment determination and subsequent years.*
- *refining two previously adopted measures beginning with the FY 2018 payment determination: (1) the Hospital-level, Risk-standardized Payment Associated with a 30-day Episode-of-Care for Pneumonia (NQF # 2579); and (2) the Patient Safety and Adverse Events Composite (NQF #0531).*
- *adding four new claims-based measures: (1) Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure; (2) Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure; (3) Spinal Fusion Clinical Episode-Based Payment Measure; and (4) Excess Days in Acute Care after Hospitalization for Pneumonia for the FY 2019 payment determination and subsequent years.*
- *Refined version of the NIH Stroke Scale for the Hospital 30-Day Mortality Following Acute Ischemic Stroke Hospitalization Measure beginning as early as the FY 2022 payment determination;*

RECORDSONE

© 2014-2016

MS-DRG Updates

CMS encourages input from our stakeholders concerning the annual IPPS updates when that input is made available to us by December 7 of the year prior to the next annual proposed rule update. For example, to be considered for any updates or changes in FY 2017, comments and suggestions should have been submitted by December 7, 2015. The comments that were submitted in a timely manner for FY 2017 are discussed in this section of the final rule. Interested parties should submit any comments and suggestions for FY 2018 by December 7, 2016, via the new CMS MS-DRG Classification Change Requests Mailbox located at:

MSDRGClassificationChange@cms.hhs.gov.

RECORDSONE

© 2014-2016

MDC 1: Mechanical Complication of Nervous System

. . . we are finalizing our proposal to reassign ICD-10-CM diagnosis codes ***T85.610A, T85.620A, T85.630A, and T85.690A*** *from MDC 21 under MS-DRGs 919, 920, and 921 to MDC 1 under MS-DRGs 091, 092, and 093.*

Also moved 18 T85 codes from MDC 21 to MDC 1:

T85.615A, T85.625A, T85.635A, T85.695A, T85.730A, T85.731A, T85.732A, T85.733A, T85.734A, T85.735A, T85.738A, T85.810A, T85.820A, T85.830A, T85.840A, T85.850A, T85.860A, T85.890A

RECORDSONE

© 2014-2016

MDC 4: Reassignment of R22.2

. . . we are finalizing our proposal to reassign ICD-10-CM diagnosis code R22.2 from MDC 4 to MDC 9 under MS-DRGs 606 and 607 (Minor Skin Disorders with and without MCC, respectively).

R22.2 Localized swelling, mass and lump, trunk

Excludes1: intra-abdominal or pelvic mass and lump (R19.0-)
intra-abdominal or pelvic swelling (R19.0-)
Excludes2: breast mass and lump (N63)

RECORDSONE
© 2014-2016

MDC 4: Pulmonary Embolism with tPA or TT

. . . we are finalizing our proposal to not create a new MS-DRG or to reassign cases with a principal diagnosis of pulmonary embolism with tPA or other thrombolytic therapy for FY 2017. The current structure of MS-DRGs 175 and 176 (Pulmonary Embolism with and without MCC, respectively) is maintained in the ICD-10 MS-DRGs Version 34 effective October 1, 2016.

Alteplase Treatment of Acute Pulmonary Embolism in the Intensive Care Unit, CriticalCareNurse Vol 33, No. 2, APRIL 2013

RECORDSONE

© 2014-2016

MDC 5: Implant of Loop Recorder (ILR)

. . . we are finalizing our proposal to designate the following four ICD-10-PCS codes as O.R. procedures within Appendix E of the Version 34 ICD-10 MS-DRG Definitions Manual:

0JH602Z (Insertion of monitoring device into chest subcutaneous tissue and fascia, open approach);
0JH632Z (Insertion of monitoring device into chest subcutaneous tissue and fascia, percutaneous approach);
0JWT02Z (Revision of monitoring device in trunk subcutaneous tissue and fascia, open approach); and
0JWT32Z (Revision of monitoring device in trunk subcutaneous tissue and fascia, percutaneous approach).

We also are finalizing our proposal that the ICD-10 MS-DRG assignment for the above four ICD-10-PCS procedure codes replicate the ICD-9-CM based MS-DRG assignment for procedure code 37.79;

RECORDSONE

© 2014-2016

MDC 5: Endovascular Thrombectomy of Lower Limbs

. . . We are finalizing the assignment of the ICD-10-PCS procedure codes describing endovascular thrombectomy of the lower limbs listed in the following table to ICD-10 Version 34 MS-DRGs 270, 271 and 272 for FY 2017 (which reflects the removal of the 34 proposed procedure codes and the addition of the 2 procedure codes discussed in our response above).

ICD-10-PCS Endovascular Thrombectomy Procedure Codes Reassigned to MS-DRGs 270, 271, and 272 for FY 2017	
04CK3ZZ	Extirpation of matter from right femoral artery, percutaneous approach
04CL3ZZ	Extirpation of matter from left femoral artery, percutaneous approach
04CM3ZZ	Extirpation of matter from right popliteal artery, percutaneous approach
04CN3ZZ	Extirpation of matter from left popliteal artery, percutaneous approach
04CP3ZZ	Extirpation of matter from right anterior tibial artery, percutaneous approach
04CQ3ZZ	Extirpation of matter from left anterior tibial artery, percutaneous approach
04CR3ZZ	Extirpation of matter from right posterior tibial artery, percutaneous approach
04CS3ZZ	Extirpation of matter from left posterior tibial artery, percutaneous approach
04CV3ZZ	Extirpation of matter from right foot artery, percutaneous approach
04CW3ZZ	Extirpation of matter from left foot artery, percutaneous approach
04CY3ZZ	Extirpation of matter from lower artery, percutaneous approach
06CM3ZZ	Extirpation of matter from right femoral vein, percutaneous approach
06CN3ZZ	Extirpation of matter from left femoral vein, percutaneous approach
06CP3ZZ	Extirpation of matter from right greater saphenous vein, percutaneous approach
06CQ3ZZ	Extirpation of matter from left greater saphenous vein, percutaneous approach
06CR3ZZ	Extirpation of matter from right lesser saphenous vein, percutaneous approach
06CS3ZZ	Extirpation of matter from left lesser saphenous vein, percutaneous approach
06CT3ZZ	Extirpation of matter from right foot vein, percutaneous approach
06CV3ZZ	Extirpation of matter from left foot vein, percutaneous approach
06CY3ZZ	Extirpation of matter from lower vein, percutaneous approach

RECORDSONE
© 2014-2016

MDC 5: Pacemaker Procedure Code Combinations

. . . . we are finalizing our proposal to modify the MS-DRG logic for MS-DRGs 242, 243, and 244 to establish that cases reporting one ICD-10-PCS code from the list of procedure codes describing procedures involving pacemaker devices and one ICD-10-PCS code from the list of procedure codes describing procedures involving pacemaker leads in combination with one another will qualify the case for assignment to MS-DRGs 242, 243, and 244.

RECORDSONE

© 2014-2016

MDC 5: Cardiac Pacemaker Device Replacement

*. . . . we are finalizing our proposal to modify the MS-DRG logic for MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with and without MCC, respectively) to establish that a case reporting one ICD-10-PCS procedure code describing procedures involving pacemaker device insertions **without** any other procedure codes describing procedures involving pacemaker leads reported is assigned to MS-DRGs 258 and 259 for FY 2017.*

RECORDSONE

© 2014-2016

MDC 5: Cardiac Pacemaker Revision

. . . . we are finalizing our proposal to modify the GROUPER logic for MS-DRGs 260, 261, and 262 so that cases reporting any one of the ICD-10-PCS procedure codes describing procedures involving pacemakers and related procedures and associated devices listed in the corrected table below are assigned to MS DRGs 260, 261, and 262.

(Insertion, removal, revision)

RECORDSONE

© 2014-2016

MDC 5: Transcatheter Mitral Valve Repair with Implant

. . . After consideration of the public comments we received, we are finalizing our proposal to collapse MS-DRGs 228, 229, and 230 from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229. We also are finalizing our proposal to reassign ICD-9-CM procedure code 35.97 and the cases reporting ICD-10-PCS procedure code 02UG3JZ (Supplement mitral valve with synthetic substitute, percutaneous approach) from MS-DRGs 273 and 274 to MS-DRG 228 and revised MS-DRG 229.

In addition, we are finalizing our proposal to remove ICD-10-PCS procedure code 02UG3JZ and ICD-9-CM procedure code 35.97 from the PTCA list in MS-DRGs 231 and 232 (Coronary Bypass with PTCA with MCC and without MCC, respectively) for FY 2017.

Other Cardiothoracic Procedures			
Proposed Revised MS-DRGs	**Number of Cases**	**Average Length of Stay**	**Average Costs**
MS-DRG 228 – with MCC	1, 966	11.53	$51, 634
MS-DRG 229 – without MCC	3, 027	5.69	$34, 169

RECORDSONE
© 2014-2016

MDC 6: Excision of Ileum

. . . . we are finalizing our proposal to reassign ICD-10-PCS procedure codes 0DBB0ZZ (Excision of ileum, open approach) and 0DBA0ZZ (Excision of jejunum, open approach) from MS-DRGs 347, 348, and 349 (Anal and Stomal Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 329, 330, and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) effective with the ICD-10 MS-DRGs Version 34 on October 1, 2016.

Example: C49A3, Gastrointestinal stromal tumor (GIST) of small intestine

RECORDSONE

© 2014-2016

MDC 7: Bypass Procedures of the Veins

. . . . we are finalizing our proposal to assign ICD-10-PCS code 06183DY (Bypass portal vein to lower vein with intraluminal device, percutaneous approach) to MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas) under MS-DRGs 405, 406, and 407 (Pancreas Liver and Shunt Procedures with MCC, with CC, and without CC/MCC, respectively).

Transjugular intrahepatic portosystemic shunt (TIPS)

RECORDSONE

© 2014-2016

MDC 8: Total Ankle Replacemnt (TAR)

. . . . we are finalizing our proposal to maintain the current MS-DRG assignment for total ankle replacements in MS-DRGs 469 and 470 and not create a new MS-DRG for total ankle replacements.

Live Unedited Total Ankle Replacement - Part 1 | Thomas San Giovanni, M.D. | Doctors Hospital

RECORDSONE

© 2014-2016

MDC 8: Combination Codes for Removal and Replacement of Knee Joints

. . . . we are finalizing our proposal to add the 58 new code combinations listed above that capture the joint revisions to the Version 34 MS-DRG structure for MS-DRGs 466, 467, and 468, effective October 1, 2016.

Removal with Replacement (Clusters)

0SPB09Z	Removal of Liner from Left Hip Joint, Open Approach
***with* 0SRB02Z**	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach

RECORDSONE
© 2014-2016

MDC 8: Lordosis
(excessive curvature of the lower spine)

. . . we are finalizing our proposal to remove diagnoses codes M40.50 (Lordosis, unspecified, site unspecified); M40.55 (Lordosis, unspecified, thoracolumbar region); M40.56 (Lordosis, unspecified, lumbar region); and M40.57 (Lordosis, unspecified, lumbosacral region) from the secondary diagnosis list for MS DRGs 456, 457, and 458. These four codes are retained in the logic for the principal diagnosis list.

```
OR SECONDARY DIAGNOSIS

  M4010  Other secondary kyphosis, site unspecified
  M4012  Other secondary kyphosis, cervical region
  M4013  Other secondary kyphosis, cervicothoracic region
  M4014  Other secondary kyphosis, thoracic region
  M4015  Other secondary kyphosis, thoracolumbar region
  M4050  Lordosis, unspecified, site unspecified
  M4055  Lordosis, unspecified, thoracolumbar region
  M4056  Lordosis, unspecified, lumbar region
  M4057  Lordosis, unspecified, lumbosacral region
  M4140  Neuromuscular scoliosis, site unspecified
  M4141  Neuromuscular scoliosis, occipito-atlanto-axial region
  M4142  Neuromuscular scoliosis, cervical region
  M4143  Neuromuscular scoliosis, cervicothoracic region
  M4144  Neuromuscular scoliosis, thoracic region
  M4145  Neuromuscular scoliosis, thoracolumbar region
  M4146  Neuromuscular scoliosis, lumbar region
  M4147  Neuromuscular scoliosis, lumbosacral region
  M4150  Other secondary scoliosis, site unspecified
  M4152  Other secondary scoliosis, cervical region
  M4153  Other secondary scoliosis, cervicothoracic region
  M4154  Other secondary scoliosis, thoracic region
  M4155  Other secondary scoliosis, thoracolumbar region
  M4156  Other secondary scoliosis, lumbar region
  M4157  Other secondary scoliosis, lumbosacral region
  M438X9 Other specified deforming dorsopathies, site unspecified

9+ FUSIONS
OPERATING ROOM PROCEDURES

  0RG8070       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Tis
  0RG8071       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Tis
  0RG807J       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Tis
  0RG80A0       Fusion of 8 or more Thoracic Vertebral Joints with Interbody Fusi
  0RG80A1       Fusion of 8 or more Thoracic Vertebral Joints with Interbody Fusi
```

```
OR SECONDARY DIAGNOSIS

  M4010  Other secondary kyphosis, site unspecified
  M4012  Other secondary kyphosis, cervical region
  M4013  Other secondary kyphosis, cervicothoracic region
  M4014  Other secondary kyphosis, thoracic region
  M4015  Other secondary kyphosis, thoracolumbar region
  M4140  Neuromuscular scoliosis, site unspecified
  M4141  Neuromuscular scoliosis, occipito-atlanto-axial region
  M4142  Neuromuscular scoliosis, cervical region
  M4143  Neuromuscular scoliosis, cervicothoracic region
  M4144  Neuromuscular scoliosis, thoracic region
  M4145  Neuromuscular scoliosis, thoracolumbar region
  M4146  Neuromuscular scoliosis, lumbar region
  M4147  Neuromuscular scoliosis, lumbosacral region
  M4150  Other secondary scoliosis, site unspecified
  M4152  Other secondary scoliosis, cervical region
  M4153  Other secondary scoliosis, cervicothoracic region
  M4154  Other secondary scoliosis, thoracic region
  M4155  Other secondary scoliosis, thoracolumbar region
  M4156  Other secondary scoliosis, lumbar region
  M4157  Other secondary scoliosis, lumbosacral region
  M438X9 Other specified deforming dorsopathies, site unspecified

9+ FUSIONS
OPERATING ROOM PROCEDURES

  0RG8070       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Ti
  0RG8071       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Ti
  0RG807J       Fusion of 8 or more Thoracic Vertebral Joints with Autologous Ti
  0RG80A0       Fusion of 8 or more Thoracic Vertebral Joints with Interbody Fus
  0RG80A1       Fusion of 8 or more Thoracic Vertebral Joints with Interbody Fus
  0RG80AJ       Fusion of 8 or more Thoracic Vertebral Joints with Interbody Fus
  0RG80J0       Fusion of 8 or more Thoracic Vertebral Joints with Synthetic Sub
  0RG80J1       Fusion of 8 or more Thoracic Vertebral Joints with Synthetic Sub
  0RG80JJ       Fusion of 8 or more Thoracic Vertebral Joints with Synthetic Sub
```


RECORDSONE

© 2014-2016

MDC 13: Pelvic Evisceration/Exenteration

. . . . we are finalizing our proposal to remove the following procedure codes currently listed as a "cluster" in MDC 6 under MS-DRGs 332, 333, and 334 effective October 1, 2016 under the ICD-10 MS-DRGs Version 34. The codes will remain as a cluster in MDC 13 under MS-DRGs 734 and 735 (Pelvic Evisceration, Radical Hysterectomy and Radical Vulvectomy with CC/MCC and without CC/MCC, respectively)

ICD-10-PCS Procedure Code in Cluster	Description
0TTB0ZZ	Resection of bladder, open approach
0TTD0ZZ	Resection of urethra, open approach
0UT20ZZ	Resection of bilateral ovaries, open approach
0UT70ZZ	Resection of bilateral fallopian tubes, open approach
0UT90ZZ	Resection of uterus, open approach
0UTC0ZZ	Resection of cervix, open approach
0UTG0ZZ	Resection of vagina, open approach

RECORDSONE
© 2014-2016

MDC 19: MS-DRG 884 (Organic Disturbances and Mental Retardation)

*. . . . we are finalizing our proposal to modify the title for ICD–10 MS–DRG 884. The finalized title for MS–DRG 884 for the FY 2017 ICD–10 MS–DRGs Version 34 is "MS–DRG 884 (Organic Disturbances and **Intellectual Disability**)," effective October 1, 2016.*

APA Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

Intellectual Disability

RECORDSONE

© 2014-2016

MDC 23: MS-DRGs 945 and 946 (Rehabilitation with and without CC/MCC

. . . . we are finalizing our proposal to maintain the current structure of MS-DRGs 945 and 946. We look forward to working with the public on updates to the ICD-10-PCS guidelines or updates to ICD-10-CM to better capture these services. Once we receive ICD-10 claims data, we will again examine this issue . . . . Therefore, it is necessary to wait for ICD-10 claims data in order to evaluate and propose MS-DRG updates.

K. Admissions/Encounters for Rehabilitation

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

RECORDSONE
© 2014-2016

Medicare Code Editor (MCE) Changes

. . . . we are finalizing our proposal to remove all the ICD-10-CM diagnoses in the code range of P00 through P96 from the newborn diagnosis category in the Age conflict code edit list for the ICD-10 MCE for FY 2017. The procedure codes listed in [Table 6P.1a]. associated with this final rule (which is available via the Internet on the CMS Web site at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

are the finalized list of procedure codes that will be removed from the newborn diagnosis category in the Age conflict code edit list in the ICD-10 MCE Version 34 effective October 1, 2016.

Definition of Medicare Code Edits v34 [ZIP, 1MB]

RECORDSONE

© 2014-2016

Age conflict edit

. . . . we are finalizing our proposal to remove the 12 ICD-10-CM diagnosis codes in the F90 through F98 code range displayed earlier in this section from the pediatric diagnosis category Age conflict edit code list in the ICD-10 MCE Version 34, effective October 1, 2016.

ICD-10-CM Diagnosis Code	Description
F93.0	Separation anxiety disorder of childhood
F93.8	Other childhood emotional disorders
F93.9	Childhood emotional disorder, unspecified
F94.1	Reactive attachment disorder of childhood
F94.2	Disinhibited attachment disorder of childhood
F94.8	Other childhood disorders of social functioning
F94.9	Childhood disorder of social functioning, unspecified
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood
F98.8	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F98.9	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

RECORDSONE

© 2014-2016

Age conflict edit: Pediatric BMI

. . . . we are finalizing our proposal to remove the four ICD-10-CM diagnosis codes displayed earlier in this section that identify the body mass index for pediatric patients from the pediatric diagnosis category on the Age conflict edit code list in the ICD-10 MCE Version 34

ICD-10-CM Diagnosis Code	Description
Z68.51	Body mass index (BMI) pediatric, less than 5th percentile for age
Z68.52	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
Z68.54	Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

RECORDSONE

© 2014-2016

Age conflict edit: Pediatric Other

. . . . we are finalizing our proposal to remove the following four ICD-10-CM diagnosis codes from the pediatric diagnosis category on the Age conflict edit code list in the ICD-10 MCE Version 34

- *R62.50 (Unspecified lack of expected normal physiological development in childhood);*
- *R62.52 (Short stature (child));*
- *R62.59 (Other lack of expected normal physiological development in childhood); and*
- *Y93.6A (Activity, physical games generally associated with school recess, summer camp and children).*

RECORDSONE

© 2014-2016

Sex conflict edit: HRT / Breast prosthesis

. . . under ICD-10-CM, the diagnosis code Z79.890, Hormone replacement therapy (postmenopausal), can be reported for both men and women.

. . . we are finalizing our proposal to remove ICD-10-CM diagnosis code Z79.890 (Hormone replacement therapy (postmenopausal)) from the Diagnosis for females only edit code

Z44.31	Encounter for fitting and adjustment of external right breast prosthesis
Z44.32	Encounter for fitting and adjustment of external left breast prosthesis
Z45.811	Encounter for adjustment or removal of right breast implant
Z45.812	Encounter for adjustment or removal of left breast implant
Z45.819	Encounter for adjustment or removal of unspecified breast implant

RECORDSONE

© 2014-2016

Non-covered procedure edit:
Endovascular Mechanical Thrombectomy

We discovered that a replication error occurred due to an outdated ICD-9-CM entry for procedure code 00.62. This error led to ICD-10-PCS procedure codes 03CG3ZZ (Extirpation of matter from intracranial artery, percutaneous approach) and 05CL3ZZ (Extirpation of matter from intracranial vein, percutaneous approach) being listed as comparable translations for ICD-9-CM code 00.62. As a result, ICD-10-PCS procedure code 03CG3ZZ was included on the ICD-10 MCE Version 33 Non-covered procedure edit code list.

ICD-10-PCS Procedure Code	Description
03CG3ZZ	Extirpation of matter from intracranial artery, percutaneous approach
03CG4ZZ	Extirpation of matter from intracranial artery, percutaneous endoscopic approach
05CL3ZZ	Extirpation of matter from intracranial vein, percutaneous approach
05CL4ZZ	Extirpation of matter from intracranial vein, percutaneous endoscopic approach

CMS Manual System, Pub 100-20 One-Time Notification, Transmittal 1672
(June 16, 2016)

Contractors shall REMOVE all 'extirpation' related ICD-10 PCS codes from the SSM edits effective 10/1/15. The 8 ICD-10 PCS codes are: 03CH3ZZ, 03CJ3ZZ, 03CK3ZZ, 03CL3ZZ, 03CM3ZZ, 03CN3ZZ, 03CP3ZZ, 03CQ3ZZ

RECORDSONE

© 2014-2016

Non-covered procedure edit: Sterilization

Destruction, occlusion, excision - Fallopian tubes, Vas deferens, Spermatic cord

Non-covered procedures only when ICD-10-CM diagnosis code Z30.2 (Encounter for sterilization) is listed as the principal diagnosis.

Table 6P.1b--List of ICD-10-PCS procedure codes that relate to the proposed new Non-Covered Procedure Edit for Sterilization

RECORDSONE

© 2014-2016

Unacceptable PDX: Z381, Z384

. . . . we are finalizing our proposal to remove codes Z38.1 (Single liveborn infant, born outside hospital); Z38.4 (Twin liveborn infant, born outside hospital); and Z38.7 (Other multiple liveborn infant, born outside hospital) from the Unacceptable principal diagnosis edit code list in the ICD-10 MCE Version 34

CDC: Trends in Out-of-Hospital Births in the United States, 1990–2012

RECORDSONE
© 2014-2016

Unacceptable PDX: Multiple Gestation

There are 68 ICD-10-CM diagnosis codes included on the ICD-10 MCE Version 33 Unacceptable principal diagnosis edit code list as comparable translations that describe multiple gestation and status of the placenta.

. . . we agree this was a replication error that incorrectly included the ICD-10-CM diagnosis codes that identify both concepts (multiple gestation and status of placenta) in a single code on the ICD-10 MCE. The edit cannot isolate the status of placenta for the ICD-10 MCE because it is reported in combination with the multiple gestation as a single code. Therefore, it is inappropriate to include these codes on the unacceptable principal diagnosis edit code list.

ICD-9-CM Diagnosis Code	Description
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)
V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)
V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs
V91.10	Triplet gestation, unspecified number of placenta and unspecified

ICD-9-CM Diagnosis Code	Description
	number of amniotic sacs
V91.11	Triplet gestation, with two or more monochorionic fetuses
V91.12	Triplet gestation, with two or more monoamniotic fetuses
V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs
V91.20	(Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs
V91.21	Quadruplet gestation, with two or more monochorionic fetuses
V91.22	Quadruplet gestation, with two or more monoamniotic fetuses
V91.29	Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs
V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs
V91.91	Other specified multiple gestation, with two or more monochorionic fetuses
V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses
V91.99	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs

RECORDSONE

© 2014-2016

Unacceptable PDX: Supervision of High Risk Pregnancy

. . . we are not finalizing our proposal to remove all the ICD-10-CM diagnosis codes related to high-risk pregnancy currently listed in Table 6P.1d. associated with the proposed rule and this final rule

The ICD-10-CM diagnosis codes listed in Table 6P.1d. will continue to be subject to the Unacceptable principal diagnosis edit in the ICD-10 MCE Version 34

2) ***Supervision of High-Risk Pregnancy***

Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign code O80, Encounter for full-term uncomplicated delivery.

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

NIH: What is a high-risk pregnancy?

RECORDSONE
© 2014-2016

Other MCE: 5A1955Z, Respiratory Ventilation > 96 Consecutive Hours

*The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four **consecutive** days during the length of stay" in the ICD-10 MCE Version 34*

The finalized title for MS-DRG 208 (Respiratory System Diagnosis with Ventilator Support <= 96 Hours) is included in the ICD-10 MS-DRGs Version 34, effective October 1, 2016.

RECORDSONE

© 2014-2016

Age conflict edit: Maternity Diagnoses

. . . . we are finalizing our proposal to add ICD-10-CM diagnosis codes C58 (Malignant neoplasm of placenta), D39.2 (Neoplasm of uncertain behavior of placenta), and F53 (Puerperal psychosis) to the Age conflict edit code list for maternity diagnosis in the ICD-10 MCE Version 34

- *C58 (Malignant neoplasm of placenta)*
- *D39.2 (Neoplasm of uncertain behavior of placenta)*
- *F53 (Puerperal psychosis)*

Postpartum Psychiatric Disorders

RECORDSONE

© 2014-2016

Manifestation codes

. . . . we are finalizing our

proposal to add the diagnosis codes in subcategory M02.8 as displayed in the table in the proposed rule and above to the Manifestation codes not allowed as principal diagnosis edit code list in the ICD-10 MCE Version 34

ICD-10-CM Diagnosis Code	Description
M02.80	Other reactive arthropathies, unspecified site
M02.811	Other reactive arthropathies, right shoulder
M02.812	Other reactive arthropathies, left shoulder
M02.819	Other reactive arthropathies, unspecified shoulder
M02.821	Other reactive arthropathies, right elbow
M02.822	Other reactive arthropathies, left elbow
M02.829	Other reactive arthropathies, unspecified elbow
M02.831	Other reactive arthropathies, right wrist
M02.832	Other reactive arthropathies, left wrist
M02.839	Other reactive arthropathies, unspecified wrist
M02.841	Other reactive arthropathies, right hand
M02.842	Other reactive arthropathies, left hand
M02.849	Other reactive arthropathies, unspecified hand
M02.851	Other reactive arthropathies, right hip
M02.852	Other reactive arthropathies, left hip
M02.859	Other reactive arthropathies, unspecified hip
M02.861	Other reactive arthropathies, right knee
M02.862	Other reactive arthropathies, left knee

Reactive arthritis

RECORDSONE
© 2014-2016

Questionable admission edit

. . . . we are finalizing our proposal to remove the five ICD-10-CM diagnosis codes listed in the proposed rule and

above (T81.81XA, T88.4XXA, T88.7XXA, T88.8XXA, and T88.9XXA) from the ICD-10 MCE Questionable admission edit for the ICD-10 MCE Version 34

- T81.81XA (Complication of inhalation therapy, initial encounter);
- T88.4XXA (Failed or difficult intubation, initial encounter);
- T88.7XXA (Unspecified adverse effect of drug or medicament, initial encounter);
- T88.8XXA (Other specified complications of surgical and medical care, not elsewhere classified, initial encounter); and
- T88.9XXA (Complication of surgical and medical care, unspecified, initial encounter).

RECORDSONE
© 2014-2016

Open biopsy check / bilateral procedure edit

. . . . we are finalizing our proposal to remove the references to the open biopsy check and the bilateral procedure edit from the ICD-10 MCE Version 34

RECORDSONE

© 2014-2016

Changes to the MS-DRG Diagnosis Codes for FY 2017

- Table 6I.1—Proposed Additions to the MCC List
- Table 6I.2—Proposed Deletions to the MCC List
- Table 6J.1—Proposed Additions to the CC List
- Table 6J.2—Proposed Deletions to the CC List

(Hydronephrosis with renal and ureteral calculous obstruction), should be recognized as a principal diagnosis that acts as its own CC. Accordingly, ICD-10-CM code N13.0 (Hydronephrosis with ureteropelvic junction obstruction) was included in Table 6M (Proposed Principal Diagnosis Is Its Own CC List-FY 2017) and Table 6M.1 (Proposed Additions to the Principal Diagnosis Is Its Own CC List – FY 2017)

RECORDSONE

© 2014-2016

FY 2017 Final Rule Tables

Tables 6A-6J.2, 6K, 6L-6M.1 and 6P.1a-6P.4k:

Table 6A-New Diagnosis Codes; Table 6B-New Procedure Codes; Table 6C-Invalid Diagnosis Codes; Table 6D-Invalid Procedure Codes; Table 6E-Revised Diagnosis Codes Titles; Table 6F-Revised Procedure Codes Titles; Table 6G.1- Secondary Diagnosis Order Additions to the CC Exclusions List; Table 6G.2- Principal Diagnosis Order Additions to the CC Exclusions List; Table 6H.1- Secondary Diagnosis Order Deletions to the CC Exclusions List; Table 6H.2- Principal Diagnosis Order Deletions to the CC Exclusions List; Table 6I- Complete Major Complication and Comorbidity (MCC) List; Table 6I.1- Additions to MCC List; Table 6I.2- Deletions to MCC List; Table 6J- Complete Complication and Comorbidity (CC) List; Table 6J.1- Additions to CC List; Table 6J.2- Deletions to CC List; Table 6K- Complete List of CC Exclusions; Table 6L- Principal Diagnosis Is Its Own MCC List ; Table 6M- Principal Diagnosis Is Its Own CC List ; Table 6M.1- Additions to the Principal Diagnosis Is Its Own CC List ;

Tables 6P.1a-6P.4k (FY 2017 ICD-10-CM and ICD-10-PCS Codes for MCE and MS-DRG Changes): See summary tab in excel spreadsheet called:

"CMS-1655- F TABLE 6P ICD-10-CM and ICD-10-PCS Codes for MCE and MS-DRG Changes.xlsx"

RECORDSONE

© 2014-2016

Procedure Codes in MS DRGs 981 - 989

. . . we are removing the following 10 ICD-10-PCS procedure codes from Table 6P.2, Prostatic O.R. Procedures, (which was associated with the FY 2017 proposed rule)

- *0T7D7ZZ (Dilation of urethra, via natural or artificial opening);*
- *0T7D8ZZ (Dilation of urethra, via natural or artificial opening endoscopic);*
- *0VB03ZX (Excision of prostate, percutaneous approach, diagnostic);*
- *0VB04ZX (Excision of prostate, percutaneous endoscopic approach, diagnostic);*
- *0VB07ZX (Excision of prostate, via natural or artificial opening, diagnostic);*
- *0VB08ZX (Excision of prostate, via natural or artificial opening endoscopic, diagnostic);*
- *0VP470Z (Removal of drainage device from prostate and seminal vesicles, via*
- *natural or artificial opening);*
- *0VP473Z (Removal of infusion device from prostate and seminal vesicles, via*
- *natural or artificial opening);*
- *0VP480Z (Removal of drainage device from prostate and seminal vesicles, via*
- *natural or artificial opening endoscopic); and*
- *0VP483Z (Removal of infusion device from prostate and seminal vesicles, via*
- *natural or artificial opening endoscopic).*

RECORDSONE
© 2014-2016

Procedure Codes in MS DRGs 981 - 989

. . . we proposed to change the status of a number of ICD-10-PCS procedure codes from O.R. to non-O.R. Among the list in Table 6P.4b. associated with the proposed rule were procedures describing the endoscopic/transorifice removal of drainage, infusion, intraluminal or monitoring devices.

(Table 6P.4b - endoscopic/transorifice removal of drainage, infusion, intraluminal or monitoring devices; 155 PCS codes)

Example: *"0DP673Z","Removal of Infusion Device from Stomach, Via Natural or Artificial Opening","97.59 Removal of other device from digestive system","43.0 Gastrotomy"*

RECORDSONE

© 2014-2016

Angioplasty of extracranial vessel

. . . we are finalizing our proposal to add the above listed codes to ICD-10 MS-DRGs 037, 038, and 039 (Extracranial Procedures with MCC, with CC, or without CC/MCC, respectively) under MDC 1 for the ICD-10 MS-DRGs Version 34

ICD-10-PCS Procedure Code	Description
037H04Z	Dilation of right common carotid artery with drug-eluting intraluminal device, open approach
037H0DZ	Dilation of right common carotid artery with intraluminal device, open approach
037H0ZZ	Dilation of right common carotid artery, open approach
037J04Z	Dilation of left common carotid artery with drug-eluting intraluminal device, open approach
037J0DZ	Dilation of left common carotid artery with intraluminal device, open approach
037J0ZZ	Dilation of left common carotid artery, open approach
037K04Z	Dilation of right internal carotid artery with drug-eluting intraluminal device, open approach
037K0DZ	Dilation of right internal carotid artery with intraluminal device, open approach
037K0ZZ	Dilation of right internal carotid artery, open approach
037L04Z	Dilation of left internal carotid artery with drug-eluting intraluminal device, open approach
037L0DZ	Dilation of left internal carotid artery with intraluminal device, open approach
037L0ZZ	Dilation of left internal carotid artery, open approach
037M04Z	Dilation of right external carotid artery with drug-eluting intraluminal device, open approach
037M0DZ	Dilation of right external carotid artery with intraluminal device, open approach
037M0ZZ	Dilation of right external carotid artery, open approach
037N04Z	Dilation of left external carotid artery with drug-eluting intraluminal device, open approach
037N0DZ	Dilation of left external carotid artery with intraluminal device, open approach
037N0ZZ	Dilation of left external carotid artery, open approach
037P04Z	Dilation of right vertebral artery with drug-eluting intraluminal device, open approach
037P0DZ	Dilation of right vertebral artery with intraluminal device, open approach
037P0ZZ	Dilation of right vertebral artery, open approach
037Q04Z	Dilation of left vertebral artery with drug-eluting intraluminal device, open approach
037Q0DZ	Dilation of left vertebral artery with intraluminal device, open approach
037Q0ZZ	Dilation of left vertebral artery, open approach
037Y04Z	Dilation of upper artery with drug-eluting intraluminal device, open approach
037Y0DZ	Dilation of upper artery with intraluminal device, open approach
037Y0ZZ	Dilation of upper artery, open approach
057M0DZ	Dilation of right internal jugular vein with intraluminal device, open approach
057M0ZZ	Dilation of right internal jugular vein, open approach
057N0DZ	Dilation of left internal jugular vein with intraluminal device, open approach
057N0ZZ	Dilation of left internal jugular vein, open approach
057P0DZ	Dilation of right external jugular vein with intraluminal device, open approach
057P0ZZ	Dilation of right external jugular vein, open approach
057Q0DZ	Dilation of left external jugular vein with intraluminal device, open approach
057Q0ZZ	Dilation of left external jugular vein, open approach
057R0DZ	Dilation of right vertebral vein with intraluminal device, open approach
057R0ZZ	Dilation of right vertebral vein, open approach
057S0DZ	Dilation of left vertebral vein with intraluminal device, open approach
057S0ZZ	Dilation of left vertebral vein, open approach
057T0DZ	Dilation of right face vein with intraluminal device, open approach
057T0ZZ	Dilation of right face vein, open approach

RECORDSONE
© 2014-2016

Excision of abdominal arteries

A replication issue for 34 ICD-10-PCS procedure codes describing aneurysmectomy procedures with the open and percutaneous endoscopic approach was identified after implementation of the ICD-10 MS-DRGs Version 33.

Codes added to MDC 6, MDC 11, MDC 21, MDC 24

ICD-10-PCS Procedure Code	Description
04B10ZZ	Excision of celiac artery, open approach
04B14ZZ	Excision of celiac artery, percutaneous endoscopic approach
04B20ZZ	Excision of gastric artery, open approach
04B24ZZ	Excision of gastric artery, percutaneous endoscopic approach
04B30ZZ	Excision of hepatic artery, open approach
04B34ZZ	Excision of hepatic artery, percutaneous endoscopic approach
04B40ZZ	Excision of splenic artery, open approach
04B44ZZ	Excision of splenic artery, percutaneous endoscopic approach
04B50ZZ	Excision of superior mesenteric artery, open approach
04B54ZZ	Excision of superior mesenteric artery, percutaneous endoscopic approach
04B60ZZ	Excision of right colic artery, open approach
04B64ZZ	Excision of right colic artery, percutaneous endoscopic approach
04B70ZZ	Excision of left colic artery, open approach
04B74ZZ	Excision of left colic artery, percutaneous endoscopic approach
04B80ZZ	Excision of middle colic artery, open approach
04B84ZZ	Excision of middle colic artery, percutaneous endoscopic approach
04B90ZZ	Excision of right renal artery, open approach
04B94ZZ	Excision of right renal artery, percutaneous endoscopic approach
04BA0ZZ	Excision of left renal artery, open approach
04BA4ZZ	Excision of left renal artery, percutaneous endoscopic approach
04BB0ZZ	Excision of inferior mesenteric artery, open approach
04BB4ZZ	Excision of inferior mesenteric artery, percutaneous endoscopic approach

ICD-10-PCS Procedure Code	Description
04BC0ZZ	Excision of right common iliac artery, open approach
04BC4ZZ	Excision of right common iliac artery, percutaneous endoscopic approach
04BD0ZZ	Excision of left common iliac artery, open approach
04BD4ZZ	Excision of left common iliac artery, percutaneous endoscopic approach
04BE0ZZ	Excision of right internal iliac artery, open approach
04BE4ZZ	Excision of right internal iliac artery, percutaneous endoscopic approach
04BF0ZZ	Excision of left internal iliac artery, open approach
04BF4ZZ	Excision of left internal iliac artery, percutaneous endoscopic approach
04BH0ZZ	Excision of right external iliac artery, open approach
04BH4ZZ	Excision of right external iliac artery, percutaneous endoscopic approach
04BJ0ZZ	Excision of left external iliac artery, open approach
04BJ4ZZ	Excision of left external iliac artery, percutaneous endoscopic approach

RECORDSONE
© 2014-2016

Excision of retroperitoneal tissue

. . . . we are finalizing our proposal to add ICD-10-PCS codes 0WBH0ZZ (Excision of retroperitoneum, open approach), 0WBH3ZZ (Excision of retroperitoneum, percutaneous approach), and 0WBH4ZZ (Excision of retroperitoneum, percutaneous endoscopic approach) to MDC 6 in MS-DRGs 356 through 358 (Other Digestive System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) for the ICD-10 MS-DRGs Version 34

RECORDSONE

© 2014-2016

Excision of vulva

. . . . we are finalizing our proposal to add ICD-10-PCS procedure code 0UBMXZZ (Excision of vulva, external approach) to MDC 13 under MS-DRG 746 (Vagina, cervix and vulva procedures with CC/MCC) and MS-DRG 747 (Vagina, Cervix and Vulva procedures without CC/MCC) for the ICD-10 MS-DRGs Version 34

RECORDSONE

© 2014-2016

Lymph node biopsy

. . . we are finalizing our proposal to add ICD-10-PCS procedure codes 07B74ZX (Excision of thorax lymphatic, percutaneous endoscopic approach, diagnostic), 07B70ZX (Excision of thorax lymphatic, open approach, diagnostic) and 07B73ZX (Excision of thorax lymphatic, percutaneous approach, diagnostic) to MDC 4 under MS-DRGs 166 through 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) for the ICD-10 MS-DRGs Version 34

RECORDSONE
© 2014-2016

Obstetrical laceration repair

. . . we are finalizing our proposal and the commenters' recommendation to add the list of ICD-10-PCS procedure codes in the following table to [MS-DRG 774] effective October 1, 2016, for the ICD-10 MS-DRGs Version 34

ICD-10-PCS Procedure Code	Description
0DQQ0ZZ	Repair anus, open approach
0DQQ3ZZ	Repair anus, percutaneous approach
0DQQ4ZZ	Repair anus, percutaneous endoscopic approach
0DQQ7ZZ	Repair anus, via natural or artificial opening
0DQQ8ZZ	Repair anus, via natural or artificial opening endoscopic
0DQR0ZZ	Repair anal sphincter, open approach
0DQR3ZZ	Repair anal sphincter, percutaneous approach
0DQR4ZZ	Repair anal sphincter, percutaneous endoscopic approach
0TQDXZZ	Repair urethra, external approach
0UQJ0ZZ	Repair clitoris, open approach
0UQJXZZ	Repair clitoris, external approach

RECORDSONE

© 2014-2016

FY 2017 Status of Technologies Approved for FY 2016 Add-On Payments

. . . we proposed, we are discontinuing new technology add-on payments for ***Kcentra™*** *for FY 2017.*

. . . we are discontinuing new technology add-on payments for the ***Argus® II System*** *for FY 2017*

. . . we are discontinuing new technology add-on payments for the ***MitraClip® System*** *for FY 2017*

We are finalizing our proposal to discontinue making new technology add-on payments for the ***RNS® System*** *for FY 2017*

. . . we are finalizing our proposal to continue new technology add-on payments for the ***CardioMEMS™ HF Monitoring System*** *for FY 2017*

. . . we are finalizing our proposal to continue new technology add-on payments for ***BLINCYTO®*** *for FY 2017*

. . . we are finalizing our proposal and continuing new technology add-on payments for both the ***LUTONIX® and IN PACT™ Admiral™*** *for FY 2017*

RECORDSONE
© 2014-2016

FY 2017 Applications for New Technology Add-On Payments

Approved:

MAGEC® Spinal Bracing and Distraction System (MAGEC® Spine) - $15,750

Idarucizumab - $1,750

Defitelio® (Defibrotide) - $75,900
(ICD-10-PCS procedure codes **XW03392** and **XW04392**)

GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE) - $5,250

Vistogard™ (Uridine Triacetate) - $37,500

Not Approved:

MIRODERM Biologic Wound Matrix (MIRODERM)

Titan Spine (Titan Spine Endoskeleton® nanoLOCK™ Interbody Device)

RECORDSONE
© 2014-2016

Hospital Readmissions Reduction Program: Changes for FY 2017

- acute myocardial infarction (AMI), heart failure (HF),
- pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA)
- chronic obstructive pulmonary disease (COPD)
- Hospital-Level, 30-Day, All-Cause, Unplanned Readmission Following Coronary Artery Bypass Graft (CABG) Surgery.

For FY 2017, we proposed to use MedPAR claims with discharge dates that are on or after July 1, 2012, and no later than June 30, 2015, consistent with our historical use of a 3-year applicable period.

RECORDSONE

© 2014-2016

Hospital Readmissions Reduction Program: CABG Excess Readmission Exclusions

- discharged against medical advice
- patients who die during the initial hospitalization
- the first CABG admission for inclusion in the measure and exclude subsequent CABG admissions
- Admissions for patients without at least 30 days post-discharge enrollment in Medicare FFS

The public reporting of excess readmission ratios will be posted on an annual basis to the Hospital Compare Web site as soon as is feasible following the review period.

© 2014-2016

Hospital Value-Based Purchasing (VBP)

- Total Performance Score (TPS)
- CMS publishing proxy value-based incentive payment adjustment factors in Table 16A
- PSI 90 Measure in the FY 2018 Program and Future Program Years

AHRQ needs a full year of nationally representative ICD-10 coded data before it can complete development of risk-adjusted models based on a national reference population. At this time, a risk adjusted ICD-10 version of the modified PSI 90 software is not expected to be available until late CY 2017.

The Agency for Healthcare Research and Quality (AHRQ) held a Webinar on August 1, 2016, to provide an overview of the AHRQ Quality Indicators (QIs) and the updated QI toolkit.

RECORDSONE

© 2014-2016

Hospital Value-Based Purchasing (VBP)

Previously Adopted Measures and Newly Finalized Measure Refinements for the FY 2019 Program Year±		
Short Name	**Domain/Measure Name**	**NQF #**
Person and Community Engagement Domain*		
HCAHPS	HCAHPS + 3-Item Care Transition Measure	0166 0228
Clinical Care Domain		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	0468
THA/TKA	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Safety Domain		
CAUTI**	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI**	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site	0753

RECORDSONE
© 2014-2016

Hospital Value-Based Purchasing (VBP)

Previously Adopted Measures and Newly Finalized Measure Refinements for the FY 2019 Program Year±		
Short Name	**Domain/Measure Name**	**NQF #**
SSI	Infection (SSI) Outcome Measure	
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
PSI 90	Patient Safety for Selected Indicators (Composite Measure)	0531
PC-01	Elective Delivery	0469
Efficiency and Cost Reduction Domain		
MSPB	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	2158

± We are changing some of the short names for measures from previous years' rulemakings to align these names with the usage in the Hospital IQR Program, and we are changing some measure names from previous years' rulemakings to use complete NQF-endorsed measure names.
* In section IV.H.3.b. of the preamble of this final rule, we finalized changing the name of this domain from Patient- and Caregiver-Centered Experience of Care/Care Coordination domain to Person and Community Engagement domain beginning with the FY 2019 program year.
** As discussed in section IV.H.3.c. of the preamble of this final rule, we are finalizing inclusion of selected ward (non-ICU) locations in the measure.

RECORDSONE

© 2014-2016

Medicare Outpatient Observation Notice (MOON)

Following review of comments and final approval of the MOON under the Paperwork Reduction Act (PRA) process, hospitals and CAHs must fully implement use of the MOON no later than 90 calendar days from the date of PRA approval of the MOON.

The NOTICE Act specifically requires hospitals and CAHs to deliver both a written notice and an oral explanation of the notice to individuals who receive observation services as an outpatient for more than 24 hours.

RECORDSONE
© 2014-2016

Medicare Outpatient Observation Notice (MOON)

- *. . . hospitals and CAHs may deliver the MOON to individuals receiving observation services as an outpatient before such individuals have received more than 24 hours of observation services, and be in compliance with the written delivery requirements set forth in the NOTICE Act.*
- *The NOTICE Act requirements regarding delivery of notice to an individual who receives observation services as an outpatient for more than 24 hours, and no later than 36 hours after the time such individual begins receiving observation services (or, if sooner, upon release), do not impact or change the current requirements and guidance related to the 2-midnight policy previously issued by CMS. Hospitals will be required to adhere to all existing requirements of the 2-midnight policy, as well as adhere to the requirements set forth by the NOTICE Act.*
- *We agree with the commenters who suggested that the MOON should contain a field where a hospital will be required to state the specific reason a beneficiary is an outpatient, rather than inpatient.*

RECORDSONE

© 2014-2016

Priority. Clarity. Integrity.

nSIGHT-DRIVEN

RecordsOne is on a mission.

It is every health care vendor's responsibility to enable health systems to reduce the cost of care in the US.

We are changing health care one health system at a time, by respecting and valuing our clients, by providing affordable integrated tools for Clinical Documentation & Coding Integrity, and by customizing the tools to meet the needs of our clients and contribute to their success, clinically and financially.

Visit us at RecordsOne.com to learn more.

RECORDSONE

© 2014-2016