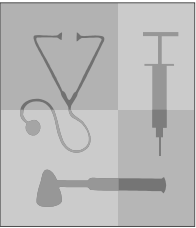



	<p><i>IPPS DRG Update FY07</i></p> <div data-bbox="401 394 725 602" data-label="Image"> </div> <div data-bbox="397 657 620 686" data-label="Text"> <p>PRESENTED TO:</p> </div> <div data-bbox="393 705 560 777" data-label="Text"> <p>HCCA October 2006</p> </div>


	Speaker
	<ul style="list-style-type: none"> • Glorianne Bryant, RHIA, RHIT, CCS <ul style="list-style-type: none"> – CHW Corporate Director Coding HIM Compliance
	<div data-bbox="1222 1791 1245 1812" data-label="Page-Footer"> <p>1</p> </div>

	AGENDA
	<ul style="list-style-type: none"> • Overview of IPPS Changes • Review of CS-DRG Changes • Other • Summary • Questions
	
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	Goals/Objectives
	<ul style="list-style-type: none"> • Participants will....Understand the rationale for the new ICD-9-CM codes • Participants willEnhance their knowledge of the clinical aspects for the diagnosis or disease/condition • Participants willImprove coding skills by coding actual case examples • Participants will Review IPPS and DRG changes for FY07
	<div> <p><i>This educational program is designed to be provide timely and accurate information regarding coding. Every reasonable effort has been made to ensure accuracy and completeness as of the date of the publication. This educational program is not intended, however, to address all situations or even a specific situation entirely. Please refer to your official coding resource materials for complete requirements.</i></p> </div>
	3

	ICD-9-CM
	<ul style="list-style-type: none"> • The ICD-9-CM diagnosis, procedure codes and IPPS changes take effect for the dates of service (DOS) on and after October 1, 2006, as well as discharges on or after October 1, 2006 for institutional providers. • (No grace period for implementation.)
	
	4

	ICD-9-CM FY07 Update
	<ul style="list-style-type: none"> • 211 new diagnosis codes • 36 new procedure codes • 60 revised codes • 33 deleted codes • <u>340 Total Coding Changes</u>
	5


	IPPS (Inpatient Prospective Payment System Update)
	<ul style="list-style-type: none"> • Proposed Rule contained significant changes to IPPS <ul style="list-style-type: none"> – Move to severity-adjusted DRGs <ul style="list-style-type: none"> • Consolidated Severity DRGs or CS-DRGs was proposed – Payment increase of 3.4% for those hospital who supply the 10 designed quality measure. Those who do not receive only a 1.4% increase. – Relative weights for DRGs will be based on cost instead of charges. – No separate DRG for severe sepsis (code 995.62) 

	IPPS Proposed Rule (con't)
	<ul style="list-style-type: none"> • Increased outlier threshold to \$25,530 • Altering EMTALA requirements • Reassign defibrillator codes in DRGs 515, 535, and 536 • Revised DRG 417 Hip/Knee Replacement to include procedure codes: 00.70, 00.80, 81.51, 81.52, 81.54, and 81.56 • Quality measures expanded • Change in “cc” list

	IPPS FINAL Rule
	<ul style="list-style-type: none"> • CMS has refined the methods used to determine average costs per case at the DRG level for relative weights. <ul style="list-style-type: none"> – For example, CMS expanded the number of distinct hospital departments used in the calculations from 10 to 13; included more hospital data in the final calculations by applying less stringent criteria for eliminating statistical outliers and accounted for hospital size when evaluating the mark-up of charges over costs. • The change will go into effect October 1, 2006 and will be phased in over a 3-year period (3-year transition to new weights). <ul style="list-style-type: none"> – 1/3 Cost for FY 2007, 2/3 Cost for FY 2008, 100% Cost for FY 2009. – In addition, CMS is announcing steps to further evaluate hospital charging practices—particularly for expensive items like medical devices—as part of considering further improvements for 2008.
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	IPPS Final Rule
	<ul style="list-style-type: none"> • The second major part of the payment reforms involves more accurate accounting for the severity of a patient's illness, which has a significant impact on costs of care. <ul style="list-style-type: none"> – In 2007, CMS is beginning the process of moving to more complete severity adjustment by adding 20 new groups to the current DRG system. • In preparation for FY 2008, CMS will conduct an evaluation, with public input, of alternative systems for more comprehensive severity adjustment as a prelude to making more comprehensive changes to better account for severity in the DRG system by FY 2008. <ul style="list-style-type: none"> – In selecting an alternative to the current system, CMS will require that hospital stakeholders have easy access to the new system. • Let's now look closer at the changes . . .
	9

	DRG Average Resources
	<ul style="list-style-type: none"> • Under the IPPS, CMS pays for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. • Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.
	10

	MedPar file
	<ul style="list-style-type: none"> • The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. • The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights.
	
	11

CMS Transition to ... Full Severity DRG IPPS

- For FY07 (October 2006):
 - Changes in the relative weight for the DRGs
 - Added 20 new severity DRGs (CS-DRG)
 - Transition phase
 - Deleted 8 DRGs
 - Modified 32 existing DRGs.



Medicare Payment Advisory Commission (MEDPAC) made several recommendations to CMS for changes in IPPS

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Severity System

Element	CMS DRG System	APR DRG System
Total number of DRGs	526	1,258
Number of CC (severity) subclasses	2	4
Multiple CCs recognized	No	Yes
CC assignment specific to base DRG	No	Yes
Logic of CC subdivision	Presence or absence	18-step process
Logic of MDC assignment	Principal diagnosis	Principal diagnosis with rerouting
Death used in DRG definitions	Yes	No
Data requirements	Hospital claims	Hospital claims

IPPS is not APR DRGs
Multiple cc recognized!?!?

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	DRG Change
	<ul style="list-style-type: none"> • The 20 new DRGs are constructed through a combination of approaches used in the proposed CS DRGs to refine the base DRGs such as: <ul style="list-style-type: none"> • Subdividing existing DRGs through the use of diagnosis codes. • Subdividing DRGs based on specific surgical procedures. • Selecting cases with specific diagnosis and/or procedure codes and assigning them to a new DRG which better accounts for their resource use and severity.
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	DRG Changes FY07. . .
	<ul style="list-style-type: none"> • MDC 1 Diseases and Disorders of the Nervous System • Deleted DRG 20 Nervous System Infection except Viral Meningitis RW 2.7865 LOS 8.0 • Created two new DRGs: <ul style="list-style-type: none"> – DRG 560 Bacterial & Tuberculosis Infections of Nervous System RW 2.9031 LOS 8.2 – DRG 561 Non-Bacterial Infections of Nervous System Except Viral Meningitis RW 2.2176 LOS 7.4
	15

	Rationale
	<ul style="list-style-type: none"> • Currently all nervous system infections except viral meningitis are combined into one DRG (DRG 20), thus grouping together patients with wide ranges of severity. • FY07 CS DRGs, will separate DRGs that distinguish bacterial infection and tuberculosis from other infections of the nervous system. • The CS DRGs divided these cases in order to better recognize severity. The codes which describe bacterial infection and tuberculosis are involved.
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	DRG Changes . . .
	<ul style="list-style-type: none"> • Deleted DRG 24 Seizure & Headache Age >17 with CC RW .9970 LOS 3.6 and DRG 25 Seizure & Headache Age >17 without CC RW .6180 LOS 2.5 • Created the following three new DRGs: <ul style="list-style-type: none"> – DRG 562 Seizure Age > 17 with CC RW 1.0582 LOS 3.7 – DRG 563 Seizure Age > 17 without CC RW .6432 LOS 2.6 – DRG 564 Headaches Age >17 RW .6933 LOS 2.6
	17

	Rationale
	<ul style="list-style-type: none"> Analysis data for patients with seizures versus those who are admitted with headaches was conducted and found that seizure cases have higher average charges than headaches. The data analysis supported creating separate DRGs for seizure and headache patients greater than 17 years of age. The clinical data and the CMS medical advisors support the creation of separate DRGs for these two groups of patients.
	18

	NEW DRGs 562 & 563
<ul style="list-style-type: none"> Diagnosis Code & Diagnosis Code Title 345.00 Generalized nonconvulsive epilepsy, without mention of intractable epilepsy 345.01 Generalized nonconvulsive epilepsy, with intractable epilepsy 345.10 Generalized convulsive epilepsy, without mention of intractable epilepsy 345.11 Generalized convulsive epilepsy, with intractable epilepsy 345.2 Petit mal status, epileptic 345.3 Grand mal status, epileptic 345.40 Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy 345.41 Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy 345.50 Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy 345.51 Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy 	<ul style="list-style-type: none"> 345.60 Infantile spasms, without mention of intractable epilepsy 345.61 Infantile spasms, with intractable epilepsy 345.70 Epilepsia partialis continua, without mention of intractable epilepsy 345.71 Epilepsia partialis continua, with intractable epilepsy 345.80 Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy 345.81 Other forms of epilepsy and recurrent seizures, with intractable epilepsy 345.90 Epilepsy, unspecified, without mention of intractable epilepsy 345.91 Epilepsy, unspecified, with intractable epilepsy 780.31 Febrile convulsions (simple), unspecified 780.32 Complex febrile convulsions 780.39 Other convulsions
	19

	DRG 564
	<ul style="list-style-type: none"> • New DRG 564: Diagnosis Code Diagnosis Code Title • 307.81 Tension headache • 310.2 Postconcussion syndrome • 346.00 Classical migraine without mention of intractable migraine • 346.01 Classical migraine with intractable migraine, so stated • 346.10 Common migraine without mention of intractable migraine • 346.11 Common migraine with intractable migraine, so stated • 346.20 Variants of migraine without mention of intractable migraine • 346.21 Variants of migraine with intractable migraine, so stated • 346.80 Other forms of migraine without mention of intractable migraine • 346.81 Other forms of migraine with intractable migraine, so stated • 346.90 Migraine, unspecified without mention of intractable migraine • 346.91 Migraine, unspecified with intractable migraine, so stated • 348.2 Benign intracranial hypertension • 349.0 Reaction to spinal or lumbar puncture • 437.4 Cerebral arteritis • 784.0 Headache
	20

	STEPS TO TAKE . . .
	<ul style="list-style-type: none"> • Run a DRG data report for DRG 24/25. • Identify the # of cases with PrDx of headache (see list) • Know the % of cases that will be impacted • Project the financial impact using these figures and your specific base rate • Talk with HIM Coding see if there are documentation issues. • Address issues, documentation improvement
	21

	DRG Changes . . .
	<ul style="list-style-type: none"> • Review of MDC 4 Diseases and Disorders of the Respiratory System • Deleted DRG 475 Respiratory System Diagnosis with Ventilator Support RW 3.6091 LOS 8.1 • Two new DRGs: <ul style="list-style-type: none"> – DRG 565 Respiratory System Diagnosis with Ventilator Support 96+ Hours RW 5.2294 – DRG 566 Respiratory System Diagnosis with Ventilator Support < 96 Hours RW 2.3335
	22

	Rationale
	<ul style="list-style-type: none"> • CMS Medical advisors agree that medical patients who are treated with mechanical ventilation for respiratory failure for 96 or <u>more hours</u> in most cases <u>are more severely ill</u> than patients who are treated with mechanical ventilation for fewer than 96 hours. <ul style="list-style-type: none"> – Review and Analysis was conducted • Decision made to split these patients based on whether or not the patients are on mechanical ventilation for 96 hours. • Deleting DRG 475 and creating two new DRGs reflecting the hours on ventilation. • Coders need to follow coding guidelines relating to hours of ventilation that can be coded. • Ventilation flow sheets need to be well documented in order to determine the # of hours.
	23

New DRGs
<ul style="list-style-type: none"> • New DRG 565 RW 5.2294 will have a respiratory system diagnosis and the following ventilation procedure code: <ul style="list-style-type: none"> – 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more) • New DRG 566 RW 2.3335 will have a respiratory system diagnosis and the following procedure codes: <ul style="list-style-type: none"> – 96.70 (Continuous mechanical ventilation of unspecified duration) – 96.71 (Continuous mechanical ventilation for less than 96 consecutive hours) • The CS DRGs recognize the difference in severity between these two groups of patients.

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Action to take
<p>Run a report on DRG 475</p> <p>Identify the # of DRGs with procedure code 96.70 (Continuous mechanical ventilation of unspecified duration) and 96.71 (Continuous mechanical ventilation for less than 96 consecutive hours)</p> <p>Identify the # of DRGs with procedure code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more)</p> <p>What % of your DRG 475 have code 96.72, which will be the higher paying new DRG</p> <p>Are there problems with respiratory documentation of ventilation, ie., difficult to determine the hours?</p>

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	DRG Changes MDC 6
	<ul style="list-style-type: none"> • MDC 6 Diseases and Disorders of the Digestive System • The eight current CMS DRGs to which these two groups of higher severity cases as assigned are as follows: <ul style="list-style-type: none"> – DRG 174 G.I. HEMORRHAGE W CC 1.0295 LOS 3.8 – DRG 175 G.I. HEMORRHAGE W/O CC 0.5806 LOS 2.4 – DRG 182 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC 0.7855 LOS 3.2 – DRG 183 MED ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC 0.5847 LOS 2.3 – DRG 184 No No 06 MED ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17 0.6196 LOS 2.5 – DRG 188 MED OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC 1.0922 LOS 4.0 – DRG 189 MED OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC 0.5913 LOS 2.4 – DRG 190 MED OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17 0.6336 LOS 2.3
	26

	DRG Changes MDC 6
	<ul style="list-style-type: none"> • Created two new DRGs: <ul style="list-style-type: none"> – DRG 571 Major Esophageal Disorders RW 1.1126 LOS 3.8 – DRG 572 Major Gastrointestinal Disorders and Peritoneal Infections RW 1.3378 LOS 5.6
	27

	DRG Changes MDC 6
	<ul style="list-style-type: none"> • New DRG 571 with the following ICD-9-CM diagnosis codes (removing them from DRGs 174, 175, 182, 183, 184, 188, 189, and 190): • Major Esophageal Disorders Diagnosis Code Titles <ul style="list-style-type: none"> • 017.80 Tuberculosis of esophagus, unspecified examination • 017.81 Tuberculosis of esophagus, bacteriological or histological examination not done • 017.82 Tuberculosis of esophagus, bacteriological or histological examination results unknown (at present) • 017.83 Tuberculosis of esophagus, tubercle bacilli found (in sputum) by microscopy • 017.84 Tuberculosis of esophagus, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture • 017.85 Tuberculosis of esophagus, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically • 017.86 Tuberculosis of esophagus, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals)
	28

	DRG Changes MDC 6
	<ul style="list-style-type: none"> • Con't Diagnosis Code Major Esophageal Disorders Diagnosis Code Titles <ul style="list-style-type: none"> • 112.84 Candidal esophagitis • 456.0 Esophageal varices with bleeding • 456.1 Esophageal varices without mention of bleeding • 456.20 Esophageal varices in diseases classified elsewhere, with bleeding • 530.4 Perforation of esophagus • 530.7 Gastroesophageal laceration-hemorrhage syndrome • 530.82 Esophageal hemorrhage • 530.84 Tracheoesophageal fistula • 750.3 Congenital tracheoesophageal fistula, esophageal atresia and stenosis • 750.4 Other specified congenital anomalies of esophagus • 862.22 Injury to esophagus without mention of open wound into cavity • 947.2 Burn of esophagus
	29

	New DRG 572
	<ul style="list-style-type: none"> • The following ICD-9-CM diagnosis codes (removing them from DRGs 182, 183, 184, 188, 189, and 190): • <u>Some</u> of the Diagnosis Code Major Gastrointestinal Disorders and Peritoneal Infections • Diagnosis Code Titles <ul style="list-style-type: none"> • 001.0 Cholera due to vibrio cholerae • 001.1 Cholera due to vibrio cholerae el tor • 001.9 Cholera, unspecified • 003.0 Salmonella gastroenteritis • 004.0 Shigella dysenteriae • 004.1 Shigella flexneri • 004.2 Shigella boydii • 004.3 Shigella sonnei • 004.8 Other specified shigella infections • 004.9 Shigellosis, unspecified • 005.0 Staphylococcal food poisoning

30

	DRG Changes . . . MDC 6
	<ul style="list-style-type: none"> • MDC 6 Diseases and Disorders of the Digestive System • CMS examined DRGs 148 and 149 Major Small & Large Bowel Procedures with and without CC, respectively with Major Gastrointestinal Diagnoses as either a principal or secondary diagnosis. • DRG 148 RW 3.4479 LOS 10.0 has been deleted • Replaced with following two new DRGs: <ul style="list-style-type: none"> – DRG 569 Major Small & Large Bowel Procedures with CC with Major Gastrointestinal Diagnosis RW 4.3425 LOS 11.9 – DRG 570 Major Small & Large Bowel Procedures with CC without Major Gastrointestinal Diagnosis RW 2.6978 LOS 8.4

31

	Rationale
	<ul style="list-style-type: none"> • CMS medical advisors agreed that these gastrointestinal surgical patients with a Major Gastrointestinal Diagnosis are more severely ill and represent patients with a higher level of severity. • New DRG 569 will have a principal diagnosis from MDC 6 and either the principal or secondary diagnosis from the major GI list. This DRG will also have an operating room procedure from current DRG 148 and Complication/Comorbidity.
	32

	Major Gastrointestinal Diagnosis
<ul style="list-style-type: none"> • Some of the Diagnosis Code Principal or Secondary Diagnosis –Major Gastrointestinal Diagnosis • Diagnosis Code Title • 008.41 Intestinal infection due to staphylococcus • 008.42 Intestinal infection due to pseudomonas • 008.43 Intestinal infection due to campylobacter • 008.45 Intestinal infection due to clostridium difficile • 008.46 Intestinal infection due to other anaerobes • 008.49 Intestinal infection due to other organisms • 014.04 Tuberculous peritonitis, tubercle bacilli not found (in sputum) by • microscopy, but found by bacterial culture • 098.86 Gonococcal peritonitis • 456.0 Esophageal varices with bleeding • 456.20 Esophageal varices in diseases classified elsewhere, with bleeding • 530.21 Ulcer of esophagus with bleeding • 530.4 Perforation of esophagus • 530.7 Gastroesophageal laceration-hemorrhage syndrome • 530.84 Tracheoesophageal fistula • 531.00 Acute gastric ulcer with hemorrhage, without mention of obstruction 	<ul style="list-style-type: none"> • Diagnosis Code Title • 531.21 Acute gastric ulcer with hemorrhage and perforation, with obstruction • 531.40 Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction • 531.41 Chronic or unspecified gastric ulcer with hemorrhage, with obstruction • 531.50 Chronic or unspecified gastric ulcer with perforation, without mention of obstruction • 531.60 Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction • 531.91 Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction • 532.00 Acute duodenal ulcer with hemorrhage, without mention of obstruction • 532.10 Acute duodenal ulcer with perforation, without mention of obstruction • 532.11 Acute duodenal ulcer with perforation, with obstruction • 532.20 Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction • 532.31 Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction • 532.40 Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction • 532.41 Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction • 532.50 Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction
	33

	Action to take
	<ul style="list-style-type: none"> • Run a DRG data report for DRG 148. • Identify the # of cases with PrDx or 2nd Dx from the “major GI Dx” • Know the % of cases that will be impacted • Project the financial impact using these figures and your base rate • Talk with HIM Coding see if there are documentation issues. • Are there problems with documentation of GI diagnosis?
	34

	DRG Changes . . .
	<ul style="list-style-type: none"> • CMS examined DRGs 154 through 156 Stomach, Esophageal & Duodenal Procedures Age >17 with and without CC and Age 0-17, respectively with Major Gastrointestinal Diagnoses present as either a principal or secondary diagnosis. • DRG 154 RW 4.0399 LOS 9.9 has been deleted • Replaced with two new DRGs as follows: <ul style="list-style-type: none"> – DRG 567 Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity with Major Gastrointestinal Diagnosis RW 5.2173 LOS 12.7 – DRG 568 Stomach, Esophageal & Duodenal Procedures Age > 17 with Complication/Comorbidity without Major Gastrointestinal Diagnosis RW 3.3635 LOS 8.3
	35

	Rationale MDC 6 . . . DRG 567/568
	<ul style="list-style-type: none"> • Again, CMS medical advisors agreed that these gastrointestinal surgical patients with a Major Gastrointestinal Diagnosis are more severely ill and represent patients with a higher level of severity. • New DRG 567 will have a principal diagnosis from MDC 6 with either a principal or secondary diagnosis of a Major Gastrointestinal Diagnosis (see list of Major Gastrointestinal Diagnoses). New DRG 567 will also have an operating room procedure from current CMS DRG 154 and a CC. • New DRG 568 will have a principal diagnosis from MDC 6, except it will not have a principal or secondary diagnosis from the list of Major Gastrointestinal Diagnoses. It will also have an operating room procedure from current CMS DRG 154 and a CC.
	36

	DRG Changes . . . MDC 11
	<ul style="list-style-type: none"> • MDC 11 Diseases and Disorders of the Kidney and Urinary Tract: Major Bladder Procedures • CMS analyzed several DRGs and removed certain procedure codes from DRGs 303-305, 308, and 309 and assigning them to new DRG 573 Major Bladder Procedures RW 3.3457 • Thus, renaming the following three DRGs: <ul style="list-style-type: none"> – DRG 303 – “Kidney and Ureter Procedures for Neoplasm” RW 1.9755 LOS 5.0 – DRG 304 – “Kidney and Ureter Procedures for Non-Neoplasm With CC” RW 2.3454 LOS 5.8 – DRG 305 – “Kidney and Ureter Procedures for Non-Neoplasm Without CC” RW 1.1521 LOS 2.5
	37

	Rationale
	<ul style="list-style-type: none"> • Five DRGs were reviewed: <ul style="list-style-type: none"> – DRG 303 (Kidney, Ureter & Major Bladder Procedures for Neoplasm) – DRG 304 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm with CC) – DRG 305 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm without CC) – DRG 308 (Minor Bladder Procedures with CC) – DRG 309 (Minor Bladder Procedures without CC) • CMS medical advisors supported creating a new DRG for major bladder procedures because they represent cases with higher levels of severity, are clinically different, and use greater resources.
	38

	DRG Changes . . . MDC 11
	<ul style="list-style-type: none"> • New DRG 573 RW 3.3457 LOS 9.1 will contain the following procedure codes: • Major Bladder Procedures Procedure Code Description • 57.6 Partial cystectomy • 57.71 Radical cystectomy • 57.79 Other total cystectomy • 57.83 Repair of fistula involving bladder and intestine • 57.84 Repair of other fistula of bladder • 57.85 Cystourethroplasty and plastic repair of bladder neck • 57.86 Repair of bladder exstrophy • 57.87 Reconstruction of urinary bladder • 57.88 Other anastomosis of bladder • 57.89 Other repair of bladder
	39

	Other DRG Changes
	<ul style="list-style-type: none"> • DRGs 315 and 316 inclusive codes revised • This is not a change in DRG assignment. But, the proposed rule assigned the newly created ICD-9-CM codes 403.00, 403.10 and 403.90 to DRGs 331-333, but since these new codes now describe <u>chronic kidney disease</u>, they should be assigned to DRGs 315 RW 2.113 & 316 RW 1.2596 (which are higher than 331-333).
	40

	DRG Changes MDC 16
	<ul style="list-style-type: none"> • MDC 16 Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders • CMS created a new DRG 574 Major Hematologic/Immunologic Diagnoses Except Sickle Cell Crisis and Coagulation Disorders. • Removed certain diagnosis codes within DRGs 395, 396, 398, and 399 and assigned them to new DRG 574 RW 1.2698 LOS 4.3
	41

	DRG Changes MDC 16 - Rationale
	<ul style="list-style-type: none"> • Some conditions are more resource intensive than other others assigned to these four DRGs. Cases with major hematological and immunological conditions had average charges of \$21,276 compared to \$11,066 to \$18,791 for the other conditions where these cases are currently assigned. <ul style="list-style-type: none"> – • DRG 395 (Red Blood Cell Disorders Age >17) – • DRG 396 (Red Blood Cell Disorders Age 0 – 17) – • DRG 398 (Reticuloendothelial & Immunity Disorders with CC) – • DRG 399 (Reticuloendothelial & Immunity Disorders without CC) • Certain diagnoses included in the above DRGs were considered to be major hematological and immunological diagnoses. • Data analysis showed that major hematological and immunological diseases identify patients with significantly greater levels of severity. These are more resource intensive than other conditions assigned to these four DRGs. <div data-bbox="1230 926 1247 940">42</div>

	DRG Changes MDC 16
	<ul style="list-style-type: none"> • CMS medical advisors agreed that major hematological and immunological disorders are found in patients with significantly greater levels of severity and are different from other conditions in the four DRGs where they are assigned. • CMS assigned new diagnosis codes indicated by an asterisk (*) to new DRG 574. These new codes also capture major hematological and immunological conditions and were created to provide more detail than the current codes in this section of ICD-9-CM. <div data-bbox="1230 1797 1247 1812">43</div>

DRG Changes MDC 16	
<ul style="list-style-type: none"> • DRG 574 Diagnosis Code Major Hematological and Immunological Code Titles • 279.11 Digeorge's syndrome • 279.12 Wiskott-aldrich syndrome • 279.13 Nezelof's syndrome • 279.19 Other deficiency of cell-mediated immunity • 279.2 Combined immunity deficiency • 283.0 Autoimmune hemolytic anemias • 283.10 Non-autoimmune hemolytic anemia, unspecified • 283.19 Other non-autoimmune hemolytic anemias • 283.2 Hemoglobinuria due to hemolysis from external causes • 283.9 Acquired hemolytic anemia, unspecified • 284.01* Constitutional red blood cell aplasia • 284.09* Other constitutional aplastic anemia • 284.8 Other specified aplastic anemias • 284.9 Aplastic anemia, unspecified • 288.00* Neutropenia, unspecified • 288.01* Congenital neutropenia • 288.02* Cyclic neutropenia • 288.03* Drug induced neutropenia • 288.04* Neutropenia due to infection • 288.09* Other neutropenia • 288.1 Functional disorders of polymorphonuclear neutrophils • 288.2 Genetic anomalies of leukocytes • 996.85 Complications of transplanted bone marrow 	
	44

DRG Changes . . . MDC 18	
<ul style="list-style-type: none"> • MDC 18 Infections and Parasitic Diseases Systemic or Unspecified Sites: O.R. Procedure for Patients with Infectious and Parasitic Diseases • Deleting DRG 415 O.R. Procedure for Infectious and Parasitic Diseases RW 3.9890 LOS 11 and divide the cases within DRG 415 into two new DRGs as follows: <ul style="list-style-type: none"> – DRG 578 Infectious and Parasitic Diseases with O.R. Procedure RW 4.8492 LOS 12.8 – DRG 579 Postoperative or Post-traumatic Infection with O.R. Procedure RW 2.8386 LOS 8.4 • Split into two new DRGs is based on whether or not the patient had postoperative or post-traumatic infection. 	
	45

	DRG Change . . . MDC 18 - Rationale
	<ul style="list-style-type: none"> • The presence or absence of one of the following principal diagnosis codes, are referred to as Postoperative or Post-Traumatic Infection: <ul style="list-style-type: none"> – 958.3, Posttraumatic wound infection, not elsewhere classified – 998.51, Infected postoperative seroma – 998.59, Other postoperative infection – 999.3, Infection complicating medical care, not elsewhere classified • Cases will be assigned to new DRG 578 if they were previously in DRG 415, but <u>do not contain</u> one of the above postoperative principal diagnosis codes.
	46

	DRG Changes . . . MDC 18
	<ul style="list-style-type: none"> • Deleting DRG 416 Septicemia Age >17 RW 1.6774 LOS 5.6 • Splitting cases into two new DRGs based on whether or not the septic patient is on mechanical ventilation for 96 or more hours. • These two new DRGs are as follows: <ul style="list-style-type: none"> – DRG 575 Septicemia with Mechanical Ventilation 96 + Hours Age >17 RW 5.9388 LOS 13.2 – DRG 576 Septicemia without Mechanical Ventilation 96 + Hours Age >17 RW 1.5953 LOS 5.5
	47

	DRG Changes . . . MDC 18 - Rationale
	<ul style="list-style-type: none"> • CMS data clearly showed that DRG 416 septicemia patients who are on mechanical ventilation for 96 or more hours have a significantly greater severity of illness level and use greater resources than do other patients in DRG 416. • Those patients on mechanical ventilation for 96 or more hours had average charges of \$94,994 compared to \$25,709 for other patients in DRG 416.
	48

	DRG Changes MDC 18
	<ul style="list-style-type: none"> • Cases will be assigned to DRG 575 RW 5.9388 when they have a principal diagnosis from current DRG 416 and code 96.72: <ul style="list-style-type: none"> – 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more) • Cases will be assigned to DRG 576 RW 1.5953 when they have a principal diagnosis from current DRG 416 and these ventilation codes: <ul style="list-style-type: none"> – 96.70 (Continuous mechanical ventilation of unspecified duration) – 96.71 (Continuous mechanical ventilation for less than 96 consecutive hours)
	49

	Other Changes . . . DRG 103
	<ul style="list-style-type: none"> • Heart Transplant or Implant of Heart Assist System: Addition of Procedure to DRG 103 • Based on public comments that CMS received, they have decided to assign an additional procedure code to DRG 103 Heart Transplant or Implant of Heart Assist System RW 18.8897 LOS 22.2 under the pre-MDCs. • The ICD-9-CM coding structure specifies that the replacement of the system be coded to 37.63 (Repair of heart assist system), and not to 37.65. <ul style="list-style-type: none"> – These cases are assigned to DRG 525 not DRG 103 even though the cases are comparable in resources expended, length of stay, etc., to other patients where the device is implanted and explanted during the same hospital stay. – Those patients received both the external heart assist device (code 37.65) and later had the device removed (code 37.64, Removal of heart assist system) after a lengthy period of rest and recovery of their native hearts.
	50

	Other Changes . . . DRG 103 con't
	<ul style="list-style-type: none"> • IPPS will now consider those cases where an external heart assist system is switched during a hospitalization, and replaced with another external heart assist system, that is subsequently removed. • Reconfiguring DRG 103 in the following manner: Those patients who have both the replacement of an external heart assist system (code 37.63) and the explantation of that system (code 37.64) prior to the hospital discharge will be assigned to DRG 103.
	51

	Other Changes
	<ul style="list-style-type: none"> • Pancreas Transplants DRG 513 RW 3.9658 LOS 8.9 • The CMS pancreas transplant NCD includes several criteria for the coverage of pancreas transplants alone, including having a diagnosis of Type I diabetes. • DRG 513 (required diabetes codes) principal or secondary diagnosis codes remains the same, as does the required operating room procedures (codes 52.80 (Pancreatic transplant NOS), and 52.82 (Homotransplant of pancreas)). • GROUPER program will to be modified to <u>remove the requirement</u> that patients also have chronic <u>kidney disease listed as principal or secondary diagnosis.</u>
	52

	Other DRG Changes . . . MDC 1
	<ul style="list-style-type: none"> • MDC 1 Diseases and Disorders of the Nervous System • Implantation of Intracranial Neurostimulator System for Deep Brain Stimulation (DBS) • Implantable dual array neurostimulator pulse generator procedure cases reported with ICD-9-CM procedure codes 02.93 and 86.95 will be reassigned to DRG 543 Craniotomy w major device implant or acute complex CNS principal rather than DRG 1 DRG 2. <ul style="list-style-type: none"> – Deep-brain stimulation (DBS) is designed to deliver electrical stimulation to the subthalamic nucleus or internal globus pallidus to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's disease and essential tremor. – DBS implants for essential tremor are unilateral, with neurostimulation leads on one side of the brain. DBS implants for Parkinson's disease are bilateral, requiring implantation of neurostimulation leads in both the left and right sides of the brain. • Changing the DRG title for DRG 543 RW 4.3496 LOS 7.9 to "Craniotomy With Major Device Implant or Acute Complex CNS Principal Diagnosis."
	53

	Other DRG Changes . . . MDC 1
	<ul style="list-style-type: none"> • Creating New DRG 577 Carotid artery stent procedure RW 1.7844 LOS 1.6 • This DRG will be hierarchically ordered above DRGs 533 RW 1.5468 LOS 2.4 Extracranial Vascular Procedures with cc and 534 RW 0.9932 LOS 1.4 Extracranial Vascular Procedures without cc. • New DRG 577 will contain two procedure codes: 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)); and 00.63 (Percutaneous insertion of carotid artery stent(s)). • Both codes <u>must</u> be reported in order for cases to be assigned to this DRG. • Coverage of the carotid artery stent procedure is limited to patients at risk of developing a stroke due to narrowing or stenosis of the carotid artery. Diagnosis code 433.10 (Occlusion and stenosis of carotid artery without mention of cerebral infarction) should be used to identify the site of the procedure in the carotid artery.
	54

	Other DRG Changes . . . MDC 5
	<ul style="list-style-type: none"> • MDC 5 Diseases and Disorders of the Circulatory System • Insertion of Epicardial Leads for Defibrillator Devices • As in the FY 2007 IPPS proposed rule (71 FR 24033), a comment indicated that a change in coding advice for the insertion of epicardial leads for CRT-D defibrillator devices affects DRG assignment. • Thus, CMS is adding the following combinations of device <u>and</u> lead codes to DRGs 515, 535, and 536: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.
	55

	Other DRG Changes . . . MDC 5
	<ul style="list-style-type: none"> • Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs - no changes this year being made. CMS will continue to study this area and look for further improvements.
	56

	Other DRG Changes . . . MDC 5
	<ul style="list-style-type: none"> • Moving the following two codes into MDC 5, DRG 479 (Other Vascular Procedures without CC), and paired DRGs 553 and 554 (Other Vascular Procedures with CC with and without Major CV Diagnosis, respectively): <ul style="list-style-type: none"> – 04.92, Implantation or replacement of peripheral neurostimulator lead(s) – 86.96, Insertion or replacement of other neurostimulator pulse generator
	57

	Other DRG Changes . . . MDC 8
	<ul style="list-style-type: none"> • MDC 8 Diseases and Disorders of the Musculoskeletal System and Connective Tissue • Hip and Knee Replacements • The DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity), which utilizes the new and revised hip and knee procedure codes under DRGs 544 and 545, also includes codes that describe procedures that are not bilateral or that do not involve multiple major joints. The new and revised joint procedure codes in October 2005 should not be assigned to DRG 471 unless they include bilateral and multiple joints. • Remove codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55 from the combinations assigned to DRG 471. These cases will be assigned to DRG 545 when used either alone or in combination.
	58

	Other DRG Changes . . . MDC 8
	<ul style="list-style-type: none"> • Remove the following codes from DRG 471: <ul style="list-style-type: none"> • 00.71, Revision of hip replacement, acetabular component • 00.72, Revision of hip replacement, femoral component • 00.73, Revision of hip replacement, acetabular liner and/or femoral head only • 00.81, Revision of knee replacement, tibial component • 00.82, Revision of knee replacement, femoral component • 00.83, Revision of knee replacement, patellar component • 00.84, Revision of total knee replacement, tibial insert (liner) • 81.53, Revision of hip replacement, not otherwise specified • 81.55, Revision of knee replacement, not otherwise specified • The revised DRG 471 will then contain only the following codes: <ul style="list-style-type: none"> • 00.70, Revision of hip replacement, both acetabular and femoral components • 00.80, Revision of knee replacement, total (all components) • 81.51, Total hip replacement • 81.52, Partial hip replacement • 81.54, Total knee replacement • 81.56, Total ankle replacement
	59

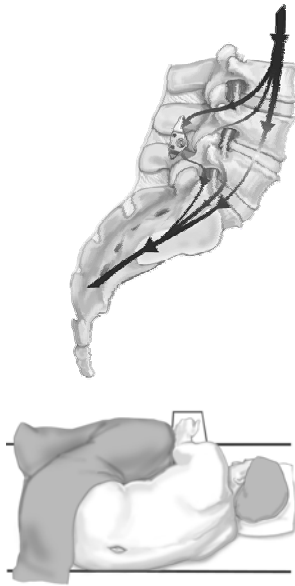
	CHARITE™ Spinal Disc Replacement Device
	<ul style="list-style-type: none"> CHARITE™ is a prosthetic intervertebral disc. Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease between L4 and S1. Recommended to change the assignments for these codes <u>from</u> DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC) <u>to</u> the DRGs for spinal fusion, DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC) for procedures on the lumbar spine and to DRGs 519 and 520 for procedures on the cervical spine. <u>NO</u> CHANGE BEING MADE.
	60

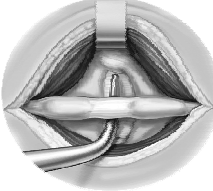
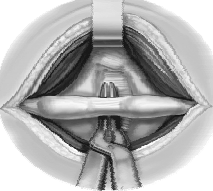
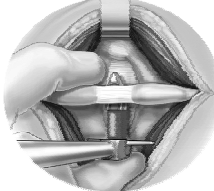
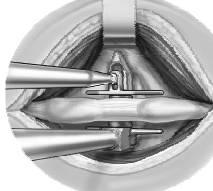
	Severe Sepsis
	<ul style="list-style-type: none"> MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)): Severe Sepsis Severe sepsis is described by ICD-9-CM code 995.92 (Systemic inflammatory response syndrome due to infection with organ dysfunction). Patients admitted with sepsis as a principal diagnosis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417 (Septicemia Age 0-17) Recommended the creation of a separate DRG for the diagnosis of severe sepsis. <u>Not creating a new DRG for severe sepsis for FY 2007.</u>
	61

	"CC"
	<ul style="list-style-type: none"> Historically, CMS developed the cc list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients.
	62

	Refinement of Complications and Comorbidities (CC) List
	<ul style="list-style-type: none"> CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Although they did not complete this review because of the work they did to develop the CS DRGs, they are considering whether to continue their analysis of the CC list as part of an effort to develop and adopt a severity DRG system that is in the public domain for FY 2008. Limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD-9-CM diagnosis coding system effective October 1, 2006.
	63

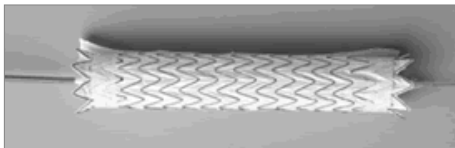
	X STOP - Interspinous Process Decompression System – Add-on Payment
	<ul style="list-style-type: none"> • CMS approved new technology add-on payments for an innovative new treatment for back pain. • The X STOP Interspinous Process Decompression System (IPD)—relieves pain, numbness and weakness caused when nerves coming from the spinal cord become compressed. • The device prevents the patient’s nerves from being compressed while preserving motion. It is the first technology to offer a minimally invasive alternative to conservative treatments (exercise, physical therapy and medication) and major back surgery. <ul style="list-style-type: none"> – Titanium alloy implant designed to stop extension (“X STOP”) – St. Francis Medical Technologies, Inc.®
	64

	The X STOP Solution
	<ul style="list-style-type: none"> • First implant to treat symptoms of Lumbar Spinal Stenosis (LSS) <ul style="list-style-type: none"> – Minimally invasive – Safe – Reversible • Patient placed in position of pain relief • Operative level(s) confirmed through fluoroscopy • Local anesthetic • 4 – 8 cm mid-sagittal incision • Inserted between spinous processes at one or two levels from L1 – L5
	 <p>The diagram illustrates the X STOP implant, a curved, metallic device designed to be placed between the spinous processes of the lumbar vertebrae. Below the implant diagram, a photograph shows a patient lying prone on a table, demonstrating the typical positioning for the minimally invasive surgical approach.</p>
	65

	X STOP IPD Technique
<div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;">  <p>Dilate interspinous ligament</p> </div> <div style="text-align: center;">  <p>Determine implant size</p> </div> <div style="text-align: center;">  <p>Insert implant into interspinous space</p> </div> <div style="text-align: center;">  <p>Secure adjustable wing</p> </div> </div> <p>Key Features:</p> <ul style="list-style-type: none"> • Procedure requires minimal incision • Tissue expander guides oval spacer through interspinous space • Technique retains SS ligament • Spinous processes are not modified 	
	66

	X Stop Add-on payment
<p>The add-on payment will be a maximum of an additional \$4,400 for cases involving this technology. CMS will pay a % of the the device charge.</p> <p>The procedure code will be ICD-9-CM 84.58 Implantation of interspinous process decompression device.</p> <p>The DRG will be either DRG 499 or 500 for Back and neck procedure except spinal fusion with/without complication/comorbidity.</p>	
	67

	Add-on payments in FY 2007
	<ul style="list-style-type: none"> • CMS will continue to make add-on payments in FY 2007 for two technologies that were approved for new technology payments in FY 2006: <ul style="list-style-type: none"> – Restore® successfully treats chronic intractable pain using a rechargeable battery allowing the patient to avoid additional surgeries to replace it. ICD-9-CM procedure code 86.98 Insertion or replacement of dual array rechargeable neurostimulator pulse generator
	68

	Add-on payments in FY 2007
	<ul style="list-style-type: none"> – GORE TAG© provides an endovascular treatment for thoracic aortic aneurysms (TAA) and avoids the need for open heart surgery. – ICD-9-CM procedure code 39.73 Endovascular implantation of graft in thoracic aorta to report this new technology.
	
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	IPPS and Quality Measures
	<ul style="list-style-type: none"> • The Centers for Medicare & Medicaid Services clarified that hospitals will have to continue submitting data on the 10 quality measures currently required of acute care hospitals, and will have to add data for 11 additional measures of heart attack, heart failure, pneumonia and surgical care beginning with patients discharged on or after July 1, 2006. • To get full Medicare payment for FY 2007, hospitals must sign and return a pledge form by Aug. 15 indicating their willingness to continue submitting the current data and to add the data for the additional measures beginning with July patients.
	70

	Reporting Hospital Quality Data
	<p style="text-align: center;">Reporting Hospital Quality Data for Annual Payment Update Notice of Participation For FY 2007 and Forward</p> <p><input type="checkbox"/> We agree to participate at this time (complete entire form including initials) <input type="checkbox"/> We do not agree to participate at this time.</p> <p>We agree to register for QualityNet Exchange and to collect the appropriate data for all payers, and will begin submitting data directly, or through a third party vendor, on the measures identified for Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) according to the published Data Transmission deadlines.</p> <p>All hospitals must complete this revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form, and send it to their QIO no later than August 15, 2006.</p> <p>Note: If your hospital is eligible to participate in the Annual Payment Update as outlined in Section 5001(a) of the Deficit Reduction Act of 2005, and chooses not to participate, your Annual Payment Update will be reduced by 2.0 percent.</p> <p>This information is in compliance with the CMS guidelines for hospitals submitting their quality performance data in accordance with Section 5001(a) of the Deficit Reduction Act of 2005. Hospitals that do not submit data for <u>all</u> required quality measures to the Clinical Data Warehouse would receive a reduction of 2.0 percent in their Medicare Annual Payment Update for the applicable fiscal year. In order to avoid the reduction in their Annual Payment Update, certain requirements must be met. CMS will determine Annual Payment Updates based on the following: 1) The Inpatient Prospective Payment System (IPPS) hospital is registered for QualityNet Exchange by the established deadline, 2) Identification of a QualityNet Administrator who follows the registration process, 3) Data are successfully submitted to CMS via the Clinical Data Warehouse by the established data transmission deadlines for each quarter, 4) Hospitals must pass validation requirements with a minimum of 80 percent reliability, based on the chart-audit validation process, 5) Hospitals must attest to the completeness and accuracy of the data submitted to the Clinical Data Warehouse, 6) Hospitals will collect and submit data into the Clinical Data Warehouse on the expanded set of measures (21 clinical quality measures) beginning with third calendar quarter of 2006 (July thru September discharges) by the established data transmission deadline of February 15, 2007, and 7) Hospitals must submit complete data in accordance with the joint CMS/CAHO sampling requirements located on the QualityNet website.</p> <p>All hospitals receiving the full market basket update will have data reported on the Hospital Compare website. This data will encompass four consecutive quarters for all measures required for RHQDAPU. Hospitals will be permitted to preview their data as we have recorded it before it is reported on Hospital Compare.</p> <p>Quality Improvement Organization: _____ Hospital Name: _____ Medicare Provider Number: _____ Street Address: _____</p>
	71

Core Measures included in the JCAHO - CMS Core Measures	
<ul style="list-style-type: none"> • Acute Myocardial Infarction (AMI) <ul style="list-style-type: none"> – AMI-1 Aspirin at Arrival – AMI-2 Aspirin Prescribed at Discharge – AMI-3 ACEI or ARB for LVSD – AMI-4 Adult Smoking Cessation Advice/Counseling – AMI-5 Beta Blocker Prescribed at Discharge – AMI-6 Beta Blocker at Arrival – AMI-7 Median Time to Thrombolysis – AMI-7a Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival – AMI-8 Median Time to PTCA – AMI-8a PCI received within 120 minutes of hospital arrival – AMI-9 JCAHO Only Inpatient mortality 	<ul style="list-style-type: none"> • Heart Failure (HF) <ul style="list-style-type: none"> – HF-1 Discharge Instructions – HF-2 LVE Assessment – HF-3 ACEI or ARB for LVSD – HF-4 Adult Smoking Cessation Advice/Counseling
<p style="text-align: center;">Know your core measures! Here are just two......source JCAHO</p>	
72	

IPPS Acronyms to Know	
<ul style="list-style-type: none"> • AHA American Hospital Association • AHIMA American Health Information Management Association • AHRO Agency for Health Care Research and Quality • AMI Acute myocardial infarction • AOA American Osteopathic Association • APR DRG All Patient Refined Diagnosis Related Group System • ASC Ambulatory surgical center • ASP Average sales price • AWP Average wholesale price • BBA Balanced Budget Act of 1997, Pub. L. 105-33 • BLS Bureau of Labor Statistics 	
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IPPS Acronyms to Know (con't)	
<ul style="list-style-type: none"> • CAH Critical access hospital • CART CMS Abstraction & Reporting Tool • CBSAs Core-based statistical areas • CC Complication or comorbidity • CDAC Clinical Data Abstraction Center • CPI Consumer price index • CMI Case-mix index • CMS Centers for Medicare & Medicaid Services • CMSA Consolidated Metropolitan Statistical Area • COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99-272 • CPI Consumer price index • CRNA Certified registered nurse anesthetist • CY Calendar year 	74

IPPS Acronyms to Know (con't)	
<ul style="list-style-type: none"> • DRA Deficit Reduction Act of 2005, Pub. L. 109-171 • DRG Diagnosis-related group • DSH Disproportionate share hospital • ECI Employment cost index • EMR Electronic medical record • EMTALA Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99-272 • FDA Food and Drug Administration • FFY Federal fiscal year • FQHC Federally qualified health center • FY Fiscal year • GAAP Generally Accepted Accounting Principles • GAF Geographic Adjustment Factor • GME Graduate medical education 	75

	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • HCFA Health Care Financing Administration • HCRIS Hospital Cost Report Information System • HHA Home health agency • HHS Department of Health and Human Services • HIC Health insurance card • HIPAA Health Insurance Portability and Accountability Act of 1996, • HIS Health information system • HIT Health information technology • HMO Health maintenance organization • HSA Health savings account • HSRVcc Hospital-specific relative value cost center • HQA Hospital Quality Alliance • HQI Hospital Quality Initiative • HwH Hospital-within-a-hospital
	76

	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • ICD-9-CM International Classification of Diseases, Ninth Revision, Clinical Modification • ICD-10-PCS International Classification of Diseases, Tenth Edition Procedure Coding System • ICU Intensive care unit • IHS Indian Health Service • IME Indirect medical education • IOM Institute of Medicine • IPF Inpatient psychiatric facility • IPPS Acute care hospital inpatient prospective payment system • IRF Inpatient rehabilitation facility • JCAHO Joint Commission on Accreditation of Healthcare Organizations
	77

	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • LTC-DRG Long-term care diagnosis-related group • LTCH Long-term care hospital • MCE Medicare Code Editor • MCO Managed care organization • MCV Major cardiovascular condition • MDC Major diagnostic category • MDH Medicare-dependent, small rural hospital • MedPAC Medicare Payment Advisory Commission • MedPAR Medicare Provider Analysis and Review File • MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173 • MRHFP Medicare Rural Hospital Flexibility Program
	78

	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • NCD National coverage determination • NCHS National Center for Health Statistics • NCQA National Committee for Quality Assurance • NCVHS National Committee on Vital and Health Statistics • NICU Neonatal intensive care unit • NQF National Quality Forum • NVHRI National Voluntary Hospital Reporting Initiative • OES Occupational employment statistics • OIG Office of the Inspector General • OMB Executive Office of Management and Budget • O.R. Operating room • OSCAR Online Survey Certification and Reporting (System)
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	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • PRM Provider Reimbursement Manual • PPI Producer price index • PPS Prospective payment system • PRA Per resident amount • ProPAC Prospective Payment Assessment Commission • PRRB Provider Reimbursement Review Board • PS&R Provider Statistical and Reimbursement (System) • QIG Quality Improvement Group, CMS • QIO Quality Improvement Organization • RHC Rural health clinic • RHQDAPU Reporting hospital quality data for annual payment update • RRC Rural referral center • RY Rate year
	80

	IPPS Acronyms to Know (con't)
	<ul style="list-style-type: none"> • SAF Standard Analytic File • SCH Sole community hospital • SNF Skilled nursing facility • SOC's Standard occupational classifications • SSA Social Security Administration • SSI Supplemental Security Income • TAG Technical Advisory Group • TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248 • UHDDS Uniform hospital discharge data set
	81


	Patient Status/Discharge Disposition Usefulness
	<ul style="list-style-type: none"> • Discharge data collection in the HIM/Medical Records Dept. via the coding & abstracting process. <ul style="list-style-type: none"> – Sometimes disposition is assigned outside of HIM and HIM performs a validation. • Medicare disposition choices for IP billing: <ul style="list-style-type: none"> - Home (01) - SNF (03) - Other Facility (nonPPS)(05)* - Chem. Depend.(05)* - AMA (07) - Expired (20) - Acute Care Transfers (02)* - ICF (04) - Psych (65) - Home Health (06)* - Rehab (62)
	82

	Medicare Patient Status/Discharge Disposition Codes
	<ul style="list-style-type: none"> • Code Structure • 41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only) • 42 Expired - place unknown (Hospice claims only) • 43 Discharge/transferred to a Federal Hospital • 50 Hospice - home • 51 Hospice - medical facility • 61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed • 63 Discharge/transfer to long term hospital
	83

Hospice Disposition Status
<ul style="list-style-type: none"> • There are currently two discharge disposition (patient status) codes that can be used for "hospice discharge". • Hospice care with UB code . . . 50 • Hospice facility with UB code. . . 51 <ul style="list-style-type: none"> • Review the following guidance from the National Uniform Billing Committee (NUBC): • <i>If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?</i> • <i>Answer: Use Code 51 Hospice - medical facility</i> <ul style="list-style-type: none"> • <i>What patient status code should be used for a patient transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:</i> • <i>a. Patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.</i> • <i>b. Patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.</i> • <i>Answer: For both conditions, use Code 51 Hospice - medical facility</i>
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http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp	
 U.S. Department of Health & Human Services  www.hhs.gov	
 Centers for Medicare & Medicaid Services Search now <input type="text"/> <input type="button" value="Search"/>	
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CMS Home > Medicare > ICD-9 Provider & Diagnostic Codes > New, Deleted, and Revised ICD-9-CM Codes - Summary Tables	
ICD-9 Provider & Diagnostic Codes <ul style="list-style-type: none"> » Overview » Process for Requesting New/Revised ICD-9-CM Procedure Codes » ICD-9-CM Coordination and Maintenance Committee Meetings » Updates and Revisions to ICD-9-CM Procedure Codes (Addendum) » CD-ROM Version Of ICD-9-CM » Diagnosis and Procedure Codes and Their Abbreviated Titles New, Deleted, and Revised ICD-9-CM Codes - Summary Tables » ICD-10-PCS Coding System and Training Manual 	New, Deleted, and Revised ICD-9-CM Codes - Summary Tables <p>This page contains new, invalid, and revised diagnosis and procedure codes. The files in the "Downloads" section include the codes with their associated descriptions.</p> <div> Downloads <ul style="list-style-type: none"> New Diagnosis Codes - Effective 10/01/2006 [PDF 120KB] - Updated 6/1/06 (final version) New Procedure Codes - Effective 10/01/2006 [PDF 40KB] - Updated 6/1/06 (final version) Invalid Diagnosis Codes - Effective 10/01/2006 [PDF 37KB] - Updated 6/1/06 (final version) Invalid Procedure Codes - Effective 10/01/2006 [PDF 22KB] - Updated 6/1/06 (final version) Revised Diagnosis Code Titles - Effective 10/01/2006 [PDF 50KB] - Updated 6/1/06 (final version) Revised Procedure Code Titles - Effective 10/01/2006 [PDF 23KB] - Updated 6/1/06 (final version) New Diagnosis Codes - Effective 10/01/2005 [PDF 32KB] </div>
	85

	References/Resources
	<ul style="list-style-type: none"> • CMS IPPS Proposed Rule FY07 • Transmittal 990 (June 23) http://www.cms.hhs.gov/transmittals/downloads/R990CP.pdf • CDC's webpage at: www.cdc.gov/nchs/icd9.htm • CMS IPPS Final Rule FY07 • Briefings on Coding Compliance Strategies, June 2006, <i>hcPRO</i> • Coding Answer Book, June 2006, DecisionHealth • X Stop website: info@sfmt europe.com
	86

	Thank you
	
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	Speaker Bio
	<p>Gloryanne Bryant, BS, RHIA, CCS</p> <p>Ms. Bryant has over 27 years of experience in the health information management profession. Gloryanne currently is the Corporate Director of Coding/HIM Compliance for Catholic Healthcare West (CHW), located in San Francisco, California. In this role Gloryanne has responsibility for the coding and documentation compliance of 40 acute care facilities and a variety of other non-hospital based healthcare entities (outpatient settings) in three states. Gloryanne has the charge of developing, implementing/setting and maintaining SystemWide coding policies, and creating an internal coding compliance auditing and monitoring team and process. She is also responsible for maintaining on-going continuing education to the CHW coding and charging staff, and providing specific documentation related education to physicians, case management, and other ancillary clinicians. In addition, she works closely with Senior Management and those involved with the CDM (Charge Description Master) and is a driving-force for regulatory updates and communication.</p> <p>Gloryanne serves as a volunteer leader for the California Health Information Association (CHIA) as a Director to the state board and has served several national positions for AHIMA (American Health Information Management Association). Gloryanne has served as a Director and Past-Chair for the Society for Clinical Coding (SCC), and served two years on the AHIMA Compliance Task Force. As a Health Information Management Practitioner in the HIM/Coding arena, she was on the AHA Editorial Advisory Board (EAB) on ICD-9-CM for <i>Coding Clinic</i> for two years and completed serving a three- year term on the Council on Accreditation for AHIMA. She continues to publish articles and agrees to be interviewed for national publications like "For the Record", "Medical Record Briefing", "CHIA Journal", "AHIMA Journal" and "Advance" magazines for HIM.</p> <p>In June 2000, <u>Gloryanne received the "CHIA Literary Award"</u>, from the California Health Information Association (CHIA) for her many articles and writings related to clinical documentation improvement, compliance, data quality and coding and in 2003 she received the CHIA award for "<u>Distinguished Member</u>". Gloryanne is a sought-after national speaker and author on healthcare compliance, clinical documentation, billing and coding regulations and serves as a catalyst for change and, improvement in healthcare. This past April '06, Ms. Bryant provided testimony on Capital Hill in support of implementation of ICD-10 by October 2009.</p>
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