CMS Finalizes Medicare Hospital Inpatient Payment Changes for FY 2011

On August 16, 2010, the Centers for Medicare and Medicaid Services (CMS) published the fiscal year (FY) 2011 Medicare hospital inpatient prospective payment system (IPPS) final rule. This rule includes policy and payment changes that apply to the diagnosis-related group (DRG)-based system that Medicare uses to reimburse most acute care hospitals for inpatient services (DRGs do not apply to critical access hospitals). Unless otherwise indicated, the final rule applies to services provided to patients who are discharged from the hospital during FY 2011, which began on October 1, 2010. Following is a summary of the provisions of the rule that may be of interest to American Red Cross hospital customers.


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Send reimbursement inquiries to reimburse@usa.redcross.org
The documentation and coding adjustment is intended to address changes in hospital coding practices that have occurred as a result of CMS’s transition to a new system of Medicare Severity Diagnosis-Related Groups (MS-DRGs) in FY 2008.

According to CMS, aggregate payments under IPPS increased in FYs 2008 and 2009 due to changes in hospital coding practices that did not reflect increases in patients’ severity of illness.

NEW ICD-9-CM DIAGNOSIS CODES FOR BLOOD INCOMPATIBILITY

The final rule includes several new International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes for ABO incompatibility, Rh incompatibility, and other types of transfusion reactions

- Previous diagnosis codes 999.6 (ABO incompatibility reaction) and 999.7 (Rh incompatibility reaction) have been deleted, and the following new codes have been added:

  ABO Incompatibility:
  • 999.60 – ABO incompatibility reaction, unspecified
  • 999.61 – ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
  • 999.62 – ABO incompatibility with acute hemolytic transfusion reaction
  • 999.63 – ABO incompatibility with delayed hemolytic transfusion reaction
  • 999.69 – Other ABO incompatibility transfusion reaction

  Rh Incompatibility:
  • 999.70 – Rh incompatibility reaction, unspecified
  • 999.71 – Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
  • 999.72 – Rh incompatibility with acute hemolytic transfusion reaction
  • 999.73 – Rh incompatibility with delayed hemolytic transfusion reaction

  Other Transfusion Reactions:
  • 999.80 – Transfusion reaction, unspecified
  • 999.83 – Hemolytic transfusion reaction, incompatibility unspecified
  • 999.84 – Acute hemolytic transfusion reaction, incompatibility unspecified
  • 999.85 – Delayed hemolytic transfusion reaction, incompatibility unspecified

- ABO incompatibility is one of the conditions subject to Medicare’s payment policy for hospital-acquired conditions (HACs), which was implemented in FY 2009. Under this policy, for certain types of cases involving secondary diagnoses (including ABO incompatibility), hospitals will not be reimbursed under a higher-paying MS-DRG unless the secondary diagnosis was present upon admission.
NEW MS-DRGs FOR BONE MARROW TRANSPLANTS

The final rule splits previous MS-DRG 009 (Bone Marrow Transplant) into two new MS-DRGs: one for allogeneic bone marrow transplants, and another for autologous bone marrow transplants.

- CMS based this MS-DRG change on a claims analysis that showed that allogeneic bone marrow transplants have higher average costs and a longer average length of stay as compared to autologous bone marrow transplants.

- Under the final rule, the payment rate for the new MS-DRG for allogeneic bone marrow transplants is nearly twice as high as the payment rate for the new MS-DRG for autologous bone marrow transplants. (Exact payment amounts vary by hospital.)

- New MS-DRG 014 (Allogeneic Bone Marrow Transplants) includes cases with one of the following ICD-9-CM procedure codes:
  - 41.02 – Allogeneic bone marrow transplant with purging
  - 41.03 – Allogeneic bone marrow transplant without purging

- New MS-DRG 015 (Autologous Bone Marrow Transplants) includes cases with one of the following ICD-9-CM procedure codes:
  - 41.05 – Allogeneic hematopoietic stem cell transplant without purging
  - 41.06 – Cord blood stem cell transplant
  - 41.08 – Allogeneic hematopoietic stem cell transplant

- According to CMS, ABO incompatibility was billed as a secondary diagnosis on only 28 IPPS claims during the period from October 2008 through September 2009, which suggests that the ABO incapability coding change should have a minimal impact on hospitals.

- The new diagnosis codes listed above have an effective date of October 1, 2010.

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THRESHOLD FOR OUTLIER PAYMENTS

CMS has set the threshold for outlier payments for unusually high-cost cases at $23,075 for FY 2011.

- This amount represents a slight decrease from the FY 2010 threshold of $23,140.

- A data analysis by Covance and the American Red Cross indicated that more than half of inpatient outlier cases involve blood-related charges.

CLARIFICATION OF THREE-DAY RULE

The final rule clarifies the situations in which services are subject to the “three-day rule,” which bundles most outpatient services into a hospital's inpatient MS-DRG payment if the services are provided in the same hospital on the day of admission or during the three calendar days prior to admission.

- Specifically, the rule states that the following outpatient services are subject to the three-day rule and, therefore, must be included on a hospital's bill for the inpatient stay:

  - All diagnostic services provided by the hospital on the day of admission or during the three calendar days prior to admission.

  - All nondiagnostic services (other than ambulance and maintenance renal dialysis services) provided by the hospital on the day of admission.

  - Nondiagnostic services (other than ambulance and maintenance renal dialysis services) provided by the hospital during the three days prior to admission, unless a hospital attests that specific nondiagnostic services are clinically unrelated to the inpatient admission (that is, the preadmission services are distinct or independent from the reason for the beneficiary's admission).

FOR MORE INFORMATION

More information on billing for blood products and related services under IPPS can be found on our Web site at redcross.org/hospitals/reimbursement, which also offers a variety of hospital outpatient reimbursement resources.

Please send reimbursement inquiries or requests for reimbursement assistance to reimburse@usa.redcross.org.