

# CMS announces quality and regulatory changes in the final 2009 INPATIENT PROSPECTIVE PAYMENT SYSTEM RULE

**O**n July 31, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the fiscal year (FY) 2009 Inpatient Prospective Payment System. The highlights of the regulation include the addition of three hospital-acquired conditions (HACs) to the previous list of eight illnesses for which Medicare will not pay if they were not present upon admission, the deletion of one and the addition of 13 quality measures that hospitals are required to report in order to receive a full payment update, and significant changes to the “stand in the shoes” aspect and period of disallowance of the physician self-referral law.

## ***HAC updates***

Since October 1, 2007, CMS has required hospitals to submit information on Medicare claims specifying whether secondary diagnoses are present upon admission. Beginning the first of this month, Medicare will no longer allow hospitals to assign an inpatient hospital discharge to a higher-paying diagnostic group if a defined HAC was not present upon admission. The HAC provision is part of a larger Medicare policy often referred to as value-based purchasing, which attempts to align payment incentives with performance to encourage the delivery of high-quality care.

The final rule made two additional conditions—manifestations of poor glycemic control and deep vein thrombosis—subject to

the HAC provision. CMS suggested these new conditions in the proposed rule issued earlier this year. In the final rule, CMS expanded the surgical site infection condition to include infection following certain orthopaedic procedures and after bariatric surgery.

CMS had originally proposed adding nine conditions to the HAC list. In a comment letter on the proposed rule, the College took the position that adding nine more conditions would be premature, would create confusion about priorities, and would excessively burden hospitals and physicians. The College also strongly opposed expanding the HAC payment policy before the first phase of implementation has been evaluated. Furthermore, the College opposed several proposed, specific HACs and, along with other medical organizations, successfully persuaded CMS to remove seven of the nine proposed conditions from the final list of conditions.

Last year, CMS selected the following eight conditions for inclusion on the HAC list: foreign object retained after surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, inpatient falls and trauma, catheter-associated urinary tract infection, vascular catheter-associated infection, and surgical site infection (limited to mediastinitis after coronary artery bypass graft). The FY 2009 final rule refined two of these conditions—foreign object retained after surgery and pressure ulcers—by updating the International Classification of Diseases, Ninth

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Revision, Clinical Modification (ICD-9-CM) codes that are subject to the HAC provisions.

See the Table that begins on this page and continues on page 20 for a complete listing of HACs selected for implementation on October 1.

### Revised quality reporting measures

The FY 2009 final rule also updates the Reporting Hospital Quality Data for Annual Payment Update Program. By law, CMS must reduce payments to hospitals that do not report specified quality measures. Hospitals that successfully report the quality measures in a given fiscal year will receive the full market-basket update in the subsequent fiscal year, whereas hospitals that fail to successfully report these measures will receive an update that is 2 percent less than the market-basket update that would otherwise apply for that fiscal year. The annual payment update program is another value-based purchasing tool that CMS is using to attempt to promote increased quality and efficiency of care.

The final rule adds 13 quality measures to the current list of 30 measures and deletes one measure, for a total of 42 measures for FY 2009 reporting. CMS originally proposed to add 43 new quality measures, but after the comment period decided to finalize only 13 measures. In the comment letter to CMS mentioned previously, the College expressed strong concern about the proposed expansion of the reporting obligations imposed on hospitals and their physicians. The College also expressed support for using existing registries and data banks to enhance and expand quality reporting without adding to the demands on hospitals and physicians. In addition, the College opposed several proposed quality measures, which CMS eventually removed from the final rule.

### Other changes

The final rule contains major changes to the “stand in the shoes” aspect and period of disallowance in the physician self-referral statute. The finalized rule requires only physician owners or investors to stand in the shoes of their physician-owned organization. In such a case, any arrangement between a physician group and an entity to which the physician group refers Medicare patients for designated health services (DHS)

### HACs selected for October 1 implementation

HAC	Complication and comorbidity (CC)/major complication and comorbidity (MCC) (ICD-9-CM codes)
Foreign object retained after surgery	998.4 (CC) 998.7 (CC)
Air embolism	999.1 (MCC)
Blood incompatibility	999.6 (CC)
Pressure ulcer, stages III and IV	707.23 (MCC) 707.24 (MCC)
Falls and trauma: • Fracture • Dislocation • Intracranial injury • Crushing injury • Burn • Electric shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-associated urinary tract infection	996.64 (CC)  Excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular catheter-associated infection	999.31 (CC)
Manifestations of poor glycemic control*	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)

*continued on next page*

\*HAC added in FY 2009 Inpatient Prospective Payment System rule.

**HACs selected for October 1 implementation (continued)**

HAC	Complication and comorbidity (CC)/ major complication and comorbidity (MCC) (ICD-9-CM codes)
Surgical site infection, mediastinitis following coronary artery bypass graft	519.2 (MCC)  Plus one of the following procedure codes: 36.10-36.19
Surgical site infection following certain orthopaedic procedures*	996.67 (CC) 998.59 (CC)  Plus one of the following procedure codes: 81.01-81.08 81.23-81.24 81.31-81.83 81.85
Surgical site infection following bariatric surgery for obesity*	Principal diagnosis: 278.01  998.59 (CC)  Plus one of the following procedure codes: 44.38 44.39 44.95
Deep vein thrombosis and pulmonary embolism following certain orthopaedic procedures*	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC)  Plus one of the following procedure codes: 00.85-00.87 81.51-81.52 81.54

\*HAC added in FY 2009 Inpatient Prospective Payment System rule.

would be analyzed under the physician self-referral statute as if the arrangement were directly between the DHS entity and the physician owners or investors. This provision does not apply to physician owners or investors who do not receive the financial

benefits of ownership or investment in the physician organization (labeled by CMS “titular owners”). This part of the rule also does not apply to arrangements that satisfy the requirements for the exception of academic medical centers. In addition, the final rule allows physicians who are not owners to choose to stand in the shoes of their physician organization, thereby allowing these physicians greater flexibility to make referrals to DHS entities. CMS proposed but did not finalize the entity “stand in the shoes” provision, which would have required a DHS entity to stand in the shoes of any entity that owns or controls it. In that case, the DHS entity would be deemed to have the same compensation arrangements, with the same parties, and on the same terms as the entity that owns or controls it.

CMS also finalized provisions that identify the period of disallowance during which a physician cannot refer to a DHS entity nor can the entity bill Medicare because the financial relationship between the two violates the self-referral statute. The final regulation, which differs minimally from the proposed rule, states that the period of disallowance begins when the financial arrangement fails to satisfy an exception to the physician self-referral statute, and ends no later than any of the following dates:

- When the agreement comes into compliance, if the noncompliance does not relate to compensation
- When the excess remuneration is returned, if the noncompliance relates to excess remuneration
- When additional money is paid, if the noncompliance relates to insufficient payment

The final rule also provides a special exception when noncompliance with the physician self-referral statute is solely the result of a missing signature.

Overall, the final rule reflects a greater focus on value-based purchasing and the evolution of the physician self-referral statute and takes into account the concerns that the College expressed in its comments. As a result, the rule reflects a more balanced approach to CMS’ quality and regulatory changes.

An online version of the final rule is available at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>. The rule was published in the August 19 issue of the *Federal Register*. [Q]