

FINAL MEDICARE DRG CHANGES FOR FY 2010

The Centers for Medicare and Medicaid Services (CMS) is revising the Medicare hospital Inpatient Prospective Payment Systems (IPPS) for FY 2010. These changes are described in the IPPS Final Rule, which is posted on the CMS web site. It was published in the August 27, 2009 **Federal Register**. Some changes are based on continued experience with this payment system, and some are in response to the 525 comments received on the FY 2010 Proposed Rule.

For FY 2010, Medicare is making only minimal updates to the MS-DRGs. There are no new DRGs, and only a few revisions to the designation of diagnosis and procedures codes under the existing MS-DRGs. In addition, the MS-DRGs incorporate FY 2010 ICD-9-CM coding changes. These changes will be effective for Medicare discharges occurring on or after October 1, 2009.

1. **MDC 8, MUSCULOSKELETAL SYSTEM, AND CONNECTIVE TISSUE:** In response to comments, CMS examined cases involving hip or knee replacements that have become infected, so that the patient must be re-admitted for removal of the prosthesis and treatment of the infection. These patients typically present with devastating complications and require extensive resources to treat. They must first undergo a procedure to remove the prosthesis and insert an antibiotic spacer to maintain space while the infection is treated. Then, the infection must be treated. These cases are identified with the following procedure codes:

CODE	DESCRIPTION
80.05	Arthrotomy for removal of prosthesis without replacement, hip
80.06	Arthrotomy for removal of prosthesis without replacement, knee

Currently, cases involving hip replacements are assigned to MS DRGs 480-482 (hip and femur procedures except major joint), and cases involving knee replacements are assigned to MS DRGs 495-497 (local excision and removal of internal fixation devices excluding hip and femur). After analysis, Medicare has determined that these cases should be moved to the following DRGs:

DRG	DESCRIPTION
463	Wnd Debridement & Skin Graft exc Hand, for Musculo-Connective Tissue
464	Wnd Debridement & Skin Graft exc Hand, for Musculo-Connective Tissue
465	Wnd Debridement & Skin Graft exc Hand, for Musculo-Connective Tissue

2. **OTHER DRG CHANGES CONSIDERED: MDC 05, CIRCULATORY SYSTEM – IFVA:** Medicare received a request to evaluate and possibly reassign coronary artery bypass graft (CABG) cases involving intra-operative fluorescence vascular angiography (IFVA). This new technology is described by procedure code 88.59 (IFVA). Currently, these cases are assigned to MS DRGs 235 and 236 (Coronary Bypass without Cardiac Catheterization w/MCC, wo/MCC). The requestor suggested re-assignment into MS DRGs 233 and 234 (Coronary Bypass with Cardiac Catheterization w/MCC, wo/MCC). However, after analysis, CMS has determined that the data does not support such a move, and believes that these cases, if reassigned to DRGs 233 and 234, would be significantly overpaid. CMS did receive a number of comments strongly supportive of the use of

IFVA in these cases, with many suggesting that CMS provide appropriate financial incentives to hospitals to invest in this new technology.

3. **SURGICAL HIERARCHY REVISIONS:** For FY 2010, CMS is not making any revisions of the surgical hierarchy for any MDC. In general, the Version 27 MS-DRGs follow the same hierarchical order as the previous Version 26 DRGs.
4. **O.R. PROCEDURES UNRELATED TO THE PRINCIPAL DIAGNOSIS:** There are nine MS-DRGs for procedures that are unrelated to the patient's principal diagnosis: MS-DRGs 981, 982, and 983 (extensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC), MS-DRGs 984, 985, and 986 (prostatic O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC), and MS-DRGs 987, 988, and 989 (non-extensive O.R. procedure unrelated to principal diagnosis with MCC, with CC, and without CC/MCC). For FY 2010, there are no changes to the procedures assigned to these DRGs.
5. **CC REFINEMENTS:** Limited changes are being made to the standard list of complications and comorbidities (CCs) and to the CC Exclusions List as a result of FY 2010 ICD-9-CM coding changes. Tables 6A and Table 6C contain CC code additions and deletions. Tables 6G and 6H (available at <http://www.cms.hhs.gov/AcuteInpatientPPS/>) contain additions to and deletions from the CC Exclusion List. Also, CMS again provides two summary tables in the Final Rule: Table 6I.1 and 6J.1 contain all of the new codes added to the major CC and CC lists. For additional information, see *Industry Insight No. 459, Final ICD-9-CM Changes for FY 2009*.

FOR FURTHER INFORMATION

If you have questions regarding the MS-DRGs changes for FY 2010, please contact our Client Services department at 1-800-999-DRGS (3747). For additional information on the IPPS Final Rule, see the following *Industry Insights*:

INSIGHT NO.	TITLE
476	Final Changes to the Medicare Code Editor (MCE) for FY 2010
477	Final Medicare Pricer Changes for FY 2010
478	Final Medicare Quality Changes for FY 2010
479	Final ICD-9-CM Changes for FY 2010

Be sure to check the Ingenix web site for additional Industry Insights on Medicare regulatory issues. You will find Industry Insights under News & Events: <http://www.ingenix.com/News/Industnews/>.