CMS WILL NO LONGER BE PROVIDING PAPER COPIES OF HANDOUTS FOR THE MEETING. ELECTRONIC COPIES OF ALL MEETING MATERIALS WILL BE POSTED ON THE CMS WEBSITE PRIOR TO THE MEETING AT HTTPS://WWW.CMS.HHS.GOV/ICD9PROVIDERDIAGNOSTICCODES/03_MEETINGS.ASP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Agenda
ICD-9-CM Coordination and Maintenance Committee
Department of Health and Human Services
Centers for Medicare & Medicaid Services
CMS Auditorium
7500 Security Boulevard
Baltimore, MD 21244-1850
ICD-9-CM Volume 3, Procedures
March 5, 2012

Pat Brooks, CMS – Introductions and Committee overview
Co-Chairperson

9:00 AM – 12:30 PM ICD-9-CM Volume 3, Procedure presentations and public comment

Note: This will be a one day meeting only. Proposals for procedure codes will be discussed from 9:00 am – 12:30 pm. Proposals for the diagnosis codes will be discussed from approximately 1:30 pm-5:00 pm by the Centers for Disease Control (CDC). Please visit CDCs website for the Diagnosis agenda located at the following address: www.cdc.gov/nchs/icd/icd9cm_maintenance.htm

Conference lines have made available for those participants who are unable to attend in person and would like to listen to the proceedings. Toll free dial in access for external participants is as follows:
Phone: 1-877-267-1577 Meeting ID: 0843
If dialing in you do NOT need to register on-line for the meeting.

ICD-10 Implementation:
HHS Announces Intent to Delay ICD-10 Compliance Date Denise Buenning, OESS

ICD-9-CM Topic

1. Administration of Fidaxomicin Pages 8-9	Celeste Beauregard Sherwood Gorbach, MD Optimer Pharmaceuticals, Inc.
2. Injection or Infusion of Glucarpidase Pages 10-11	Amy L. Gruber Suzanne Ward, Pharm D. BTG Medical Affairs

ICD-10 Topics:

1. ICD-10 MS-DRG Update Pages 13-14	Pat Brooks Janice Bonazelli, 3M
2. ICD-10 HAC Translation List Page 15	Celeste Beauregard
3. Impact of ICD-10 MS-DRGs Implementation Pages 16-22	Liz McCullough, 3M

Registering for the meeting:

Information on registering online to attend the meeting can be found at:
http://www.cms.hhs.gov/apps/events/

If dialing in you do **not** need to register online.

For questions about the registration process, please contact Mady Hue at 410-786-4510 or marilu.hue@cms.hhs.gov.

Continuing Education Credits:
Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS ICD-9-CM Coordination and Maintenance (C&M) Committee Meeting Conference Calls or on-site Meetings.

Continuing Education Information for American Academy of Professional Coders (AAPC)
If you have attended or are planning to attend a CMS ICD-9-CM Coordination and Maintenance (C&M) Committee Meeting Conference Call or on-site Meeting, you should be aware that CMS does not provide certificates of attendance for these. Instead, the AAPC will accept your e-mailed confirmation and call or meeting description as proof of participation. Please retain a copy of your e-mailed confirmation for these as the AAPC will request them for any conference call or meeting you entered into your CEU Tracker if you are chosen for CEU verification. Members are awarded one (1) CEU per hour of participation.

Continuing Education Information for American Health Information Management Association (AHIMA)
AHIMA credential-holders may claim 1 CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA, nor does a CEU certificate need to be provided, in order to claim AHIMA CEU credit. For detailed information about AHIMA's CEU requirements, see the Recertification Guide on AHIMA's web site.

Please note: The statements above are standard language provided to CMS by the AAPC and the AHIMA. If you have any questions concerning either statement, please contact the respective organization, <u>not CMS</u>.

Partial Code Freeze for ICD-9-CM and ICD-10 Finalized

The ICD-9-CM Coordination and Maintenance Committee has implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 on October 1, 2013. There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets was made on October 1, 2011.

- On October 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

- On October 1, 2014, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2014 once the partial freeze has ended.

Codes discussed at the September 15 – 16, 2010 and March 9 – 10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting were considered for implementation on October 1, 2011, the last regular updates for ICD-9-CM and ICD-10. Code requests discussed at the September 14, 2011 and additional meetings during the freeze will be evaluated for either the limited updates to capture new technologies and diseases during the freeze period or for implementation to ICD-10 on October 1, 2014. The public will be actively involved in evaluating the merits of any such requests during the period of the partial freeze.

ICD-9-CM TIMELINE

A timeline of important dates in the ICD-9-CM process is described below:

March 5, 2012	ICD-9-CM Coordination and Maintenance Committee meeting.
April 1, 2011	There will **not** be any new ICD-9-CM codes implemented on April 1, 2012 to capture new technology.
April 6, 2012	Deadline for receipt of public comments on proposed code revisions discussed at the March 5, 2012 ICD-9-CM Coordination and Maintenance Committee meeting for implementation on October 1, 2012.
April 2012	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include the finalized ICD-9-CM diagnosis and procedure codes from the September meeting for the upcoming fiscal year. Any code proposals discussed at the March meeting and finalized in time for October 1 implementation will be included in the final rule. The NPRM will also include proposed revisions to the DRG system on which the public may comment. The proposed rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
April 2012	Summary report of the Procedure part of the March 5, 2012 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the March 5, 2012 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
June 2012	Final addendum posted on web pages as follows: Diagnosis addendum at - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at – https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
July 13, 2012	Those members of the public requesting that topics be discussed at the September 19 – 20, 2012 ICD-9-CM Coordination and

	Maintenance Committee meeting must have their requests to CMS for procedures and NCHS for diagnoses.
August 1, 2012	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include all the final codes to be implemented on October 1, 2012. This rule can be accessed at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp
August 2012	Tentative agenda for the Procedure part of the September 19, 2012 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage at - https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Tentative agenda for the Diagnosis part of the September 20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on NCHS homepage at - http://www.cdc.gov/nchs/icd9.htm Federal Register notice for the September 19 –20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 17, 2012	**On-line registration opens for the September 19-20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting at: http://www.cms.hhs.gov/apps/events**
September 10, 2012	Because of increased security requirements, those wishing to attend the September 19 - 20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting must register for the meeting online at: http://www.cms.hhs.gov/apps/events **Attendees must register online by September 10, 2012; failure to do so may result in lack of access to the meeting.**
September 19 –20, 2012	ICD-9-CM Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-9-CM Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 10, 2012.** You must bring an official form of picture identification (such as a drivers license) in order to be admitted to the building.

October 2012	Summary report of the Procedure part of the September 19, 2012 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on CMS homepage as follows: https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes Summary report of the Diagnosis part of the September 20, 2012 ICD-9-CM Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd9.htm
October 1, 2012	New and revised ICD-9-CM codes go into effect along with DRG changes. Final addendum posted on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd9.htm Procedure addendum at - https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes
October 05, 2012	**Deadline for receipt of public comments on proposed code revisions discussed at the September 19-20, 2012 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on April 1, 2013.**
November 2012	Any new ICD-9-CM codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2013 will be posted on the following websites: https://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes http://www.cdc.gov/nchs/icd9.htm
November 16, 2012	**Deadline for receipt of public comments on proposed code revisions discussed at the September 19-20, 2012 ICD-9-CM Coordination and Maintenance Committee meetings for implementation on October 1, 2013.**

Administration of Fidaxomicin

Issue: Currently, the ICD-9-CM procedure code classification does not describe the administration of oral drugs. The manufacturer has requested an ICD-9-CM procedure code for the administration of DIFICID® (Fidaxomicin) for inpatients.

New Technology Application: Yes. The company has submitted a New Technology Application for FY 2013.

Food & Drug Administration (FDA) Approval: Yes. DIFICID® (Fidaxomicin) was approved on May 27, 2011 for the treatment of *Clostridium difficile*-associated diarrhea in adults 18 years of age and older.

Background of Technology: DIFICID® (Fidaxomicin) is a new generation antibacterial agent to treat *Clostridium difficile* diarrhea in over 25 years since vancomycin was approved by the FDA. Use of Vancomycin is compromised by high rates of disease recurrence as well as the risk of patients developing Vancomycin-resistant enterococcus (VRE). DIFICID® has been proven superior in achieving sustained clinical response with higher rates of complete clinical cure.

C. difficile-associated diarrhea (CDAD) is a significant medical problem in hospitals and long-term care facilities. Estimates of incidence range from 700,000 to 3 million cases per year in the U.S. Over the past decade, the incidence of CDAD has increased fivefold in the entire population and eightfold in the elderly. Advanced age is one of the most important risk factors for CDAD. Approximately two-thirds of patients are 65 years or older, making awareness and control of CDAD a major issue for the Medicare population. As more virulent strains have emerged, severity and complications have increased as well. In a recent study, hospitalized patients with CDAD had lengths of stay nearly three times longer than average and mortality rates more than four times higher. According to one estimate, up to 30% of patients with CDAD die in spite of antibiotic use or even surgery. In recent years, *C. difficile* has also surpassed MRSA as the leading cause of healthcare-acquired infections in community hospitals.

Treating *C. difficile*-associated diarrhea is particularly challenging because of the significant number of patients who experience recurrence. About 20%-30% of patients who initially respond to Vancomycin later develop recurring symptoms, usually within one to three weeks after stopping the antibiotic. In patients who have had two or more prior episodes of CDAD, the risk of further recurrence is as high as 50%-65%. Disruption of the normal bowel environment such as by the use of broad-spectrum antibiotics facilitates colonization with *C. difficile a*nd development of CDAD. Continued disruption of the normal flora also contributes to recurrence through relapse with the original strain, re-infection with a new strain, or re-infection with the original strain.

DIFICID® is a supplied as a tablet and is administered orally over the course of 10 days.

Coding Options:

Option 1. Do not create a new ICD-9-CM procedure code.

Option 2. Create a new code to describe the administration of any oral drug.

17.7 Other diagnostic and therapeutic procedures

New code 17.72 Administration of oral drug(s)

Option 3. Create a new code to describe the administration of DIFICID® (Fidaxomicin).

17.7 Other diagnostic and therapeutic procedures

New code 17.72 Administration of fidaxomicin

CMS Recommendation: Option 1; do not create a new code. Coding oral medications is not currently performed in ICD-9-CM.

Interim Coding: None recommended. The ICD-9-CM is designed to capture diagnoses and procedures. The clinical coding for oral administration of medication tablets is not considered a procedure but part of the conservative treatment of care given to inpatients during an admission. Capturing the oral administration of medication tablets using ICD-9-CM would be setting a major precedent.

Injection or Infusion of Glucarpidase

Issue: There is not a unique ICD-9-CM procedure code to describe the administration of glucarpidase (Voraxaze®) used to treat cancer patients with toxic levels of methotrexate in their blood due to impaired renal function. Should a new code be implemented?

New Technology Application:
Yes, a New Technology Add-on Payment application from the manufacturer has been submitted for FY 2013 consideration.

Food and Drug Administration (FDA) Approval:
FDA approved Voraxaze® (glucarpidase) injection on January 17, 2012 for the treatment of toxic plasma methotrexate concentrations (> 1µmol/L) in patients with delayed methotrexate clearance due to impaired renal function. Voraxaze® is marketed by BTG International, Inc.

Background:
Methotrexate is one of the most widely used anti-cancer agents and the administration of high-dose methotrexate is an important component in the treatment of a variety of cancers. One of the side effects of administering high dose methotrexate is renal dysfunction. Renal dysfunction, in turn, impairs the elimination of methotrexate, and the levels of methotrexate rise to the point of life-threatening toxicity. According to the requestor, glucarpidase causes a rapid and sustained reduction of toxic methotrexate concentrations in those patients suffering from impaired renal function. Voraxaze® works by breaking down methotrexate into its inactive metabolites which are then eliminated from the body by routes other than the kidney (primarily the liver).

Voraxaze® is the only approved pharmaceutical treatment option for patients with toxic methotrexate concentrations due to renal impairment. Other methods of treatment include: hemodialysis, hemodiafiltration, high-flux hemodialysis, charcoal hemoperfusion or hemofiltration, peritoneal dialysis, exchange transfusion or plasma exchange.

The usual maximum dosage per administration of Voraxaze® for one patient is 50 units/kg. The most common side effects of this drug observed in greater than one percent of patients in the clinical study were hypotension, headache, nausea, vomiting, flushing, and abnormal sensation (paraesthesia).

Glucarpidase is not indicated for use in patients who exhibit the expected clearance of methotrexate (plasma methotrexate concentrations within 2 standard deviations of the mean methotrexate excretion curve specific for the dose of methotrexate) or those with normal or mildly impaired renal function because of the potential risk of subtherapeutic exposure to methotrexate.

Coding Options:

1. Continue to assign the injection or infusion of glucarpidase to code 99.29, Injection or infusion of other therapeutic or prophylactic substance.

2. Create a new code to capture the injection or infusion of glucarpidase under category 00.9, Other procedures and interventions.

   New code 00.95 Injection or infusion of glucarpidase

CMS Recommendation:

Option 2. Create a new code to capture the injection or infusion of glucarpidase under category 00.9, Other procedures and interventions.

New code 00.95 Injection or infusion of glucarpidase

Interim Coding:

In the interim, continue to assign the injection or infusion of glucarpidase to code 99.29, Injection or infusion of other therapeutic or prophylactic substance.

FOR IMMEDIATE RELEASE **Contact:** HHS Press Office
February 16, 2012 (202) 690-6343

HHS Announces Intent to Delay ICD-10 Compliance Date

As part of President Obama's commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius today announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013 – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

"ICD-10 codes are important to many positive improvements in our health care system," said HHS Secretary Kathleen Sebelius. "We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system."

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

ICD-10 MS-DRG V29.0 Definitions Manual Update

Topics

- MS-DRG v29.0 Definitions Manual Update
- Samples of Comments and Actions
- Diagnoses and Procedure Description Lengths
- "Summary of Changes" Documents
- Document availability

ICD-10 MS-DRG V29.0 Definitions Manual Update

- Changes made in ICD-10 MS-DRG Definitions Manual to replicate ICD-9-CM MS-DRG v29.0 changes
  - New, deleted and redefined DRGs changes
  - New and deleted diagnoses and procedures changes
  - Procedure DRG assignment changes
  - Additions and deletions to the CC exclusion lists
  - Changes to the Hospital Acquired Conditions (HACs)
- Changes made due to additions and deletions to the ICD-10 codeset for FY2012
- Changes made thru testing and comment review

Samples of Comments and Actions

MDC 6

Comment: Requesting review of DRG assignment to Anal/Stoma Procedures vs. Major Small & Large Bowel Procedures.

Action: 0DB80ZZ (Open Excision of small intestine) was moved into MS-DRGs 329-331 (Major Small & Large Bowel Procedures).

MDC 14

Comment: Requesting review of potential DRG mismatches.

Action: Unable to review for V29.0 update. Will review for next release.

MDC 15

Comment: Z23 as secondary diagnosis generates an assignment to MS-DRG 794 Neonate w other significant problems

Action: Z23 (Encounter for immunization) was added as an "only secondary diagnosis" to MS-DRG 795 Normal Newborn.

MCC/CC changes

Comment: Requesting review of MCC/CC status of certain codes

Action: A4101 Sepsis due to Methicillin susceptible Staphylococcus aureus added as MCC

A4102 Sepsis due to Methicillin resistant Staphylococcus aureus added as MCC

ICD-10 MS-DRG V29.0 Definitions Manual Update

Diagnoses and Procedure Description Lengths

- Diagnoses and Procedure Description Lengths Finalized
  - Long descriptions – 300 characters maximum length
  - Short descriptions – 60 characters maximum length

"Summary of Changes" Documents

- Summary of changes from V28.0 to V29.0 provided in text files:
  - New, deleted and redefined DRGs
  - New and deleted diagnoses and procedures
  - Changes in DRG assignment for certain diagnoses and procedures
  - Changes in MCC/CC status, HIV Status, POA exempt list
  - Additions and deletions to the CC exclusion list
  - Changes to the Hospital Acquired Conditions (HACs)

Updated Definitions Manual and Summary of Changes

- MS-DRG V29.0 Definitions Manual
  - Available in text and HTML versions
  - Posted on CMS website at http://www.cms.gov/ICD10
- MS-DRG V29.0 "Summary of Changes" Documents
  - Will be posted on ICD-10 website at http://www.cms.gov/ICD10

Translation of HAC List to ICD-10 Codes

In anticipation of the implementation of ICD-10, CMS has begun the process of translating the ICD-9-CM HAC List to ICD-10-CM and ICD-10-PCS codes. CMS encourages the public to review the list of ICD-10-CM/PCS code translations of the current selected HACs available on our CMS Web site located at: http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp#TopOfPage.

The translations can be found under the link titled ICD-10 MS-DRG v28 R1 Definitions manual (updated October 4, 2011) - HTML Version in Appendix I Hospital Acquired Conditions (HACS) List.

We encourage the public to review these translations and to submit comments on these translations. A CMS ICD-10-CM/PCS HAC Translation Feedback Mailbox has been set up for this purpose. This feedback link is titled 'CMS HAC Feedback' and is located under the HAC website on the ICD-10-CM/PCS HACs List sub-website. Again we welcome all input on these HAC translations into ICD-10-CM/PCS.

The final HAC List translation from ICD-9-CM to ICD-10-CM/PCS will be subject to formal rulemaking.

In the meantime, we continue to encourage readers to review the educational materials and draft code sets currently available for ICD-10-CM/PCS at the CMS Web site at: http://www.cms.gov/ICD10/. In addition, the draft ICD-10-CM/PCS coding guidelines can be viewed at the CDC Web site at: http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

Objective: To estimate the impact on aggregate IPPS MS-DRG payments to hospitals and the distribution of payments across hospitals due to the transition of ICD-10

Two Approaches to ICD-10 Transition

1. Convert MS-DRGs to ICD-10
2. Map ICD-10 input data to ICD-9-CM and continue to use the ICD-9-CM version of MS-DRGs

Resources Available

- ICD-9-CM MS-DRGs from NTIS
- ICD-10 MS-DRG definitions from CMS website
  - Use to create ICD-10 MS-DRG grouper
- General Equivalence Mappings (GEMs) from CMS website
- Reimbursement Map from CMS website
  - One to one ICD-10 to ICD-9-CM map

Analysis

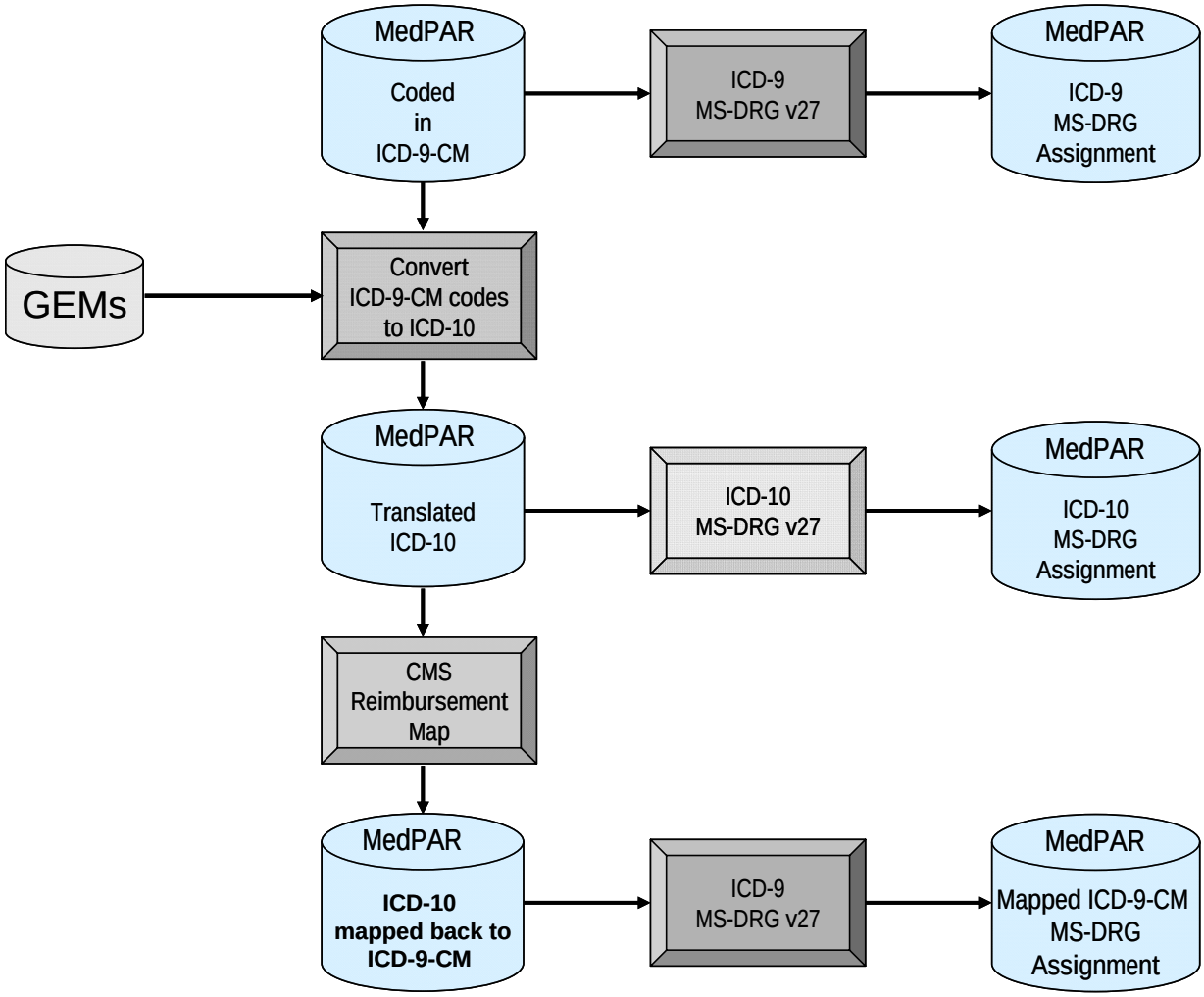
Compare payments based on the MS-DRGs assigned with ICD-9-CM coded data using the ICD-9-CM version of the MS-DRGs to:

1. Payments based on the MS-DRGs assigned with ICD-10 coded data using the ICD-10 version of the MS-DRGs.
2. Payments based on the MS-DRGs assigned with ICD-10 coded data converted back to ICD-9-CM using the Reimbursement Map using the ICD-9-CM version of the MS-DRGs

Source Data

- FY 2009 MedPAR data coded in ICD-9-CM
- FY 2009 MedPAR data converted to create a correctly coded ICD-10 version of each record

Process Overview



Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

Converting the ICD-9-CM Data to ICD-10

- For each MedPAR record, an equivalent ICD-10 record was created using the GEMs
- Due to the increased specificity of ICD-10, a single ICD-9-CM code often translates to multiple ICD-10 codes in the GEMs
- The translation process required selection of a single ICD-10 code from among the alternative possible ICD-10 translations in the GEMs
- A set of context specific translation rules was developed to automate the selection of the best possible ICD-10 translation alternative for each code on the record
- The ICD-9-CM codes on a record were *not* translated one by one, but instead the entire contents of the record were taken into account in creating an ICD-10 coded version of the record

Context Specific Translation Rules

- If an ICD-9-CM code is translated to only a single ICD-10 code in the GEMs, the ICD-9-CM code is translated to the corresponding ICD-10 code
- For ICD-9-CM codes that translate to multiple ICD-10 codes, the entire contents of the record were used to select the ICD-10 translation
  - Principal diagnosis used to select anatomic site of ICD-10 procedure
  - Sex on record used to select gender specific ICD-10 codes
  - ICD-9 codes that include multiple diseases or procedures are translated to multiple ICD-10 codes
  - When an ICD-10 code required multiple ICD-9-CM codes to replicate the full meaning of an ICD-10 code, the multiple ICD-9-CM codes are translated to a single ICD-10 code

Residual ICD-9-CM Codes with Multiple ICD-10 Translations

- Once all of context specific translation rules were applied, about 19 percent of the ICD-9-CM codes had more than one possible ICD-10 translation
- In most instances, this was due to ICD-10 having an axis of classification that was not specified in ICD-9-CM
  - Laterality: Left or right
- Since such axes of classification were not present in ICD-9-CM, they are not used to assign patients to different MS-DRGs
- Since the ICD-10 MS-DRGs replicate the ICD-9-CM MS-DRG, ICD-10 codes that differentiated patients based on attributes not contained in ICD-9-CM were assigned to the same ICD-10 MS-DRG
- Since the selection from among such ICD-10 alternative translations would have no impact on MS-DRG assignment, the final translation for theICD-9-CM code was selected randomly from among the remaining possible ICD-10 translations

Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

Simulating Payments: MS-DRG Groupings

- Three different MS-DRG groupings of the FY 2009 MedPAR data
  - Native ICD-9-CM: The ICD-9-CM MS-DRG grouper was used to assign the MS-DRGs to the source ICD-9-CM MedPAR data
  - Native ICD-10: The ICD-10 MS-DRG grouper was used to assign the MS-DRG to the ICD-10 version of the MedPAR data
  - Mapped ICD-9-CM: The ICD-10 version of the MedPAR data was mapped back to ICD-9-CM codes using the ICD-10 to ICD-9-CM Reimbursement Map. The ICD-9-CM MS-DRG grouper was then used to assign the MS-DRGs to this mapped ICD-9-CM version of the MedPAR data

Simulating Payments: Calculations

- Inlier and outlier payment calculated
- FY 2010 Medicare payment rules for operating and capital payments
  - Fixed loss threshold of $20,185 from FY 2009 final rule
- Payments applied to IPPS acute care hospitals
  - Excluding non-IPPS and hospitals with insufficient cost report information
- Data Analysis File
  - 3,383 short-term hospitals
  - 10,934,386 Medicare discharge claims

Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

Payment Impact

				Native ICD-10 vs Native ICD-9-CM		Mapped ICD-10 vs Native ICD-9-CM	
Hospital Type	Count Hospitals	Count Discharges	Tot Pay ($000,000)	% Diff MS-DRG	% Diff Payment	% Diff MS-DRG	% Diff Payment
All	3,383	10,934,355	118,964	1.68	0.05	3.66	-0.34
Top 10%	102	618,479	11,403	1.97	0.18	3.85	-0.14
All others	3,281	10,315,876	107,562	1.66	0.04	3.65	-0.36
Top 20%	676	2,585,777	35,555	1.79	0.07	3.79	-0.25
Middle 60%	2,031	6,306,899	63,944	1.66	0.04	3.59	-0.35
Bottom 20%	676	2,041,679	19,465	1.59	0.05	3.72	-0.46
Large Urban	1,336	5,268,485	63,292	1.69	0.07	3.75	-0.31
Other Urban	1,093	4,150,768	44,300	1.71	0.04	3.82	-0.38
Rural	954	1,515,102	11,372	1.56	-0.01	2.92	-0.35
Top 10%	338	3,538,531	44,150	1.73	0.08	4.00	-0.33
All other	3,045	7,395,824	74,814	1.66	0.04	3.50	-0.35

Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments

Results

- The transition from ICD-9-CM version of the MS-DRGs to the ICD-10 version of the MS-DRGs will have a minimal impact on aggregate payments to hospitals (+0.05 percent) and on the distribution of payments across hospital types (-0.01 to +0.18 percent)

- Mapping ICD-10 data back to ICD-9-CM and using the ICD-9-CM version of MS-DRGs will have a modest impact on aggregate payments to hospitals(-0.34 percent) and the distribution of payments across hospital types (-0.14 to -0.46 percent)

- Although the transition from ICD-9-CM version of the MS-DRGs to the ICD-10 version of the MS-DRGs resulted in 1.68 percent of the patients being assigned to different MS-DRGs, payment increases and decreases due to a change in MS-DRG assignment netted out

- Mapping ICD-10 data back to ICD-9-CM using the Reimbursement Map and using the ICD-9-CM version of MS-DRGs resulted in 3.66 percent of the patients being assigned to different MS-DRGs with a bias toward lower paying MS-DRGs

Mapping Issues

- The bias toward lower paying MS-DRGs was present even though the Reimbursement Map was tailored specifically for inpatient payment

- When the Reimbursement Map was applied to APR-DRGs 4.47 percent of patients changed APR-DRG
  - Using a map with a more detailed grouping system will produce even less consistent results

Optimization vs Replication

- ICD-10 MS-DRGs replicated ICD-9-CM MS-DRGs in order to make them consistent with the existing MS-DRG payment weights
- ICD-10 MS-DRGs do not take advantage of increased specificity of ICD-10
- The process of converting ICD-9-CM data to ICD-10 used in this project is sufficient for the purpose of comparing the impact of a *replicated* version of MS-DRG since additional ICD-10 specificity is not used in developing the ICD-10 MS-DRGs
- It is not possible to reliably convert an ICD-9-CM database to an ICD-10 database that corresponds to the full specificity of ICD-10 because the necessary information is simply not available in ICD-9-CM

Conclusions

- The consistency achieved between the ICD-9-CM and ICD-10 versions of the MS-DRGs demonstrates that the GEMs can provide an effective basis for converting ICD-9-CM based applications to ICD-10
- The use of mappings between ICD-10 and ICD-9-CM will produce less consistent results
- There are potential biases and unintended results if payers rely on mapping in order to continue to use ICD-9-CM based systems
  - Especially true if a payer attempts to use a single uniform mapping across all systems