FEDERAL REGISTER

Vol. 78 Monday,

No. 160 August 19, 2013

Book 2 of 2 Books

Pages 50495–51040

Part II

Department of Health and Human Services

Center for Medicare & Medicaid Services

42 CFR Parts 412, 413, 414, et al.

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Final Rule

thromboendarterectomy. The commenters stated that the proposal was reasonable, given the data and information provided.

Response: We appreciate the commenters' support.

After consideration of the public comments we received, we are finalizing our proposal to not create a new MS–DRG or to reassign cases for this alternative approach to pulmonary thromboendarterectomy.

4. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Discharge/Transfer to Designated Disaster Alternative Care Site

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27516), we proposed to add new patient discharge status code 69 (Discharged/transferred to a designated disaster alternative care site) to the MS–DRG GROUPER logic for MS–DRGs 280 (Acute Myocardial Infarction Discharged Alive with MCC), 281 (Acute Myocardial Infarction Discharged Alive with CC), and 282 (Acute Myocardial Infarction Discharged Alive without CC/MCC) to identify patients who are discharged or transferred to an alternative site that will provide basic patient care during a disaster response. As discussed in section II.G.7. of the preamble of the proposed rule, we also proposed to add this new discharge status code to the Medicare Code Editor (MCE) software. We invited public comments on this proposal.

Comment: Several commenters supported CMS' proposal to add the new patient discharge status code 69 to the MS–DRG GROUPER logic for MS–DRGs 280, 281, and 282 to identify patients who are discharged or transferred to an alternative site that will provide basic patient care during a disaster response. One commenter noted that this discharge status code would seldom be used. However, the commenter believed that the code is needed.

Response: We appreciate the commenters' support. We agree that this new discharge status code will be beneficial to identify patients who are involved in those disaster situations.

Comment: One commenter expressed concern with the proposal and questioned the purpose of implementing the new patient discharge status code 69 to only MS–DRGs 280, 281, and 282 within MDC 5.

Response: We take this opportunity to point out that the new discharge status code 69 was created and approved by the National Uniform Billing Committee (NUBC) for implementation on October 1, 2013. The purpose of adding this discharge status code 69 specifically to the GROUPER logic for MS–DRGs 280, 281, and 282 is to identify those patients diagnosed with an acute myocardial infarction (AMI) who were discharged/transferred to a designated disaster alternative care site alive. The GROUPER logic for these MS–DRGs differs from the GROUPER logic for MS–DRGs 283, 284, and 285 (Acute Myocardial Infarction, Expired with MCC, with CC, and without CC/MCC, respectively) where the patient has expired.

To further clarify, as discussed in section II.G.7.b. of the preamble of the proposed rule (78 FR 27520), this new discharge status code was also proposed to be added to the GROUPER and MCE logic. Therefore, it may be assigned to other MS–DRGs.

However, when the logic for an MS–DRG is defined by specific requirements, such as discharge status designation, the logic must be updated if a new discharge status is created to appropriately group a claim. Within MDC 5, for MS–DRGs 280, 281, and 282, the software logic is specifically defined by a patient who has been diagnosed with an AMI and is discharged alive. Assignment of the proposed new discharge status code 69 would not be valid for MS–DRGs 283, 284, and 285 where the patient has been diagnosed with an AMI and has expired. In other words, an AMI patient who has expired would not be discharged/transferred to a designated disaster alternative care site. Therefore, the addition of discharge status code 69 to the software logic for those MS–DRGs (283, 284, and 285) is not applicable within MDC 5. Alternatively, a patient who has been diagnosed with an AMI and is discharged alive would clearly have the opportunity to be discharged/transferred to a designated disaster alternative care site in a given disaster scenario or circumstance. Therefore, to ensure proper MS–DRG assignment, we proposed to add discharge status code 69 to MS–DRGs 280, 281, and 282 within MDC 5.

After consideration of the public comments we received, we are finalizing our proposal to add new patient discharge status code 69 to the MS–DRG GROUPER logic for MS–DRGs 280, 281, and 282.

b. Discharges/Transfers With a Planned Acute Care Hospital Inpatient Readmission

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27516), we also proposed to add 15 new discharge status codes to the MS–DRG GROUPER logic for MS–DRGs 280, 281, and 282 that will identify patients who are discharged with a planned acute care hospital inpatient readmission. As discussed in section II.G.7.b. of the preamble of the proposed rule, these new discharge status codes was proposed for addition to the MCE as well.

Shown in the table below are the current discharge status codes that are assigned to the GROUPER logic for MS–DRGs 280, 281, and 282, along with the proposed new discharge status codes and their titles.

Current code	New code	Discharge status code title
01	81	Discharged to home or self-care with a planned acute care hospital inpatient readmission.
02	82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission.
03	83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission.
04	84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission.
05	85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission.
06	86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission.
21	87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission.
43	88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission.
61	89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission.

Current code	New code	Discharge status code title
62	90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission.
63	91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission.
64	92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission.
65	93	Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission.
66	94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission.
70	95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission.

We invited public comments on our proposal to add the above listed new discharge status codes to the GROUPER logic for MS–DRGs 280, 281, and 282.

Comment: Commenters supported CMS' proposal to add the 15 new discharge status codes to the MS–DRG GROUPER logic for MS–DRGs 280, 281, and 282 that will identify patients who are discharged with a planned acute care hospital inpatient readmission. The commenters noted that these new discharge status codes will enable providers to better track AMI patients with planned versus unplanned readmissions.

Response: We appreciate the commenters' support. We agree that these new discharge status codes will assist in tracking patients diagnosed with an acute myocardial infarction who are discharged alive and expect to be readmitted at a later date.

Comment: One commenter stated that the addition of these 15 new discharge status codes to MS–DRGs 280–282 is unwarranted and believed that it will create a burden for providers to report and update systems. The commenter questioned if there is a timeframe associated with the use of these new discharge status codes and if this timeframe involves reporting a new discharge status code if the planned readmission is to treat the same condition as the current stay. In addition, the commenter questioned how CMS would verify that providers are applying these proposed discharge status codes appropriately. The commenter stated there are ''plenty of descriptive discharge status codes that describe where the patient is going upon discharge. To add more to clarify what is planned seems burdensome and unnecessary.'' Another commenter expressed concern with ''targeting only a small number of DRGs for a large increase in applicable discharge status codes.''

Response: The new discharge status codes related to a planned acute care hospital inpatient readmission were developed and approved by the National Uniform Billing Committee (NUBC) in response to a request by the provider community. The purpose of the new codes is to allow providers to track these types of situations when they occur. According to meeting notes from the NUBC, there is not a designated timeframe (or limitation) in reporting these new codes.

With respect to ensuring that providers apply these proposed new discharge status codes correctly, we would like to point out that the American Health Information Management Association (AHIMA) has promulgated Standards of Ethical Coding that require accurate coding that includes the reporting of all health care data elements (for example, diagnosis and procedure codes, present on admission indicator, discharge status) required for external reporting purposes (for example, reimbursement and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines. In addition, Medicare program integrity initiatives closely monitor for inaccurate coding, as well as coding inconsistent with medical record documentation.

In regard to the commenter's concern with targeting a small number of MS–DRGs with a large increase in discharge status codes, the discharge status codes were proposed to be added specifically to the GROUPER logic for MS–DRGs 280, 281, and 282 to identify those patients diagnosed with an acute myocardial infarction (AMI) who were discharged/transferred to another facility with a planned acute care hospital inpatient readmission alive. The GROUPER logic for these MS–DRGs differs from the GROUPER logic for MS–DRGs 283, 284, and 285 (Acute Myocardial Infarction, Expired with MCC, with CC, and without CC/MCC, respectively) where the patient has expired.

Similar to the discussion of discharge status code 69 in section II.G.4.a. of the preamble of this final rule, the planned readmission discharge status codes can also be reported for other MS–DRGs. We reiterate that, as discussed in section II.G.7.b. of the preamble of the proposed rule (78 FR 27520), these new discharge status codes were proposed for addition to the GROUPER and MCE logic as well.

When the logic for an MS–DRG is defined by specific requirements, such as a discharge status designation, the logic must be updated if a new discharge status is created to appropriately group a claim. Within MDC 5, for MS–DRGs 280, 281, and 282, the software logic is specifically defined by a patient who has been diagnosed with an AMI and is discharged alive. As such, the GROUPER logic requires that these discharge status codes for planned readmissions be added to the specific AMI DRGs where the patient has been discharged alive. An AMI patient who expired would not have a planned readmission. Therefore, these discharge status codes would not apply to MS–DRGs 283, 284, and 285 within MDC 5. Therefore, to ensure proper MS–DRG assignment, we proposed to add the 15 discharge status codes describing a planned readmission to MS–DRGs 280, 281, and 282 within MDC 5.

After consideration of the public comments we received, we are finalizing our proposal to add the above listed 15 new patient discharge status codes describing a planned acute care hospital inpatient readmission to the MS–DRG GROUPER logic for MS–DRGs 280, 281, and 282, effective October 1, 2013.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Reverse Shoulder Procedures

We received a request to change the MS–DRG assignment for reverse shoulder replacement procedures which