A Risk Management Perspective

The Inpatient Prospective Payment System Final Rules for 2008 and 2009

November 2008

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Brief Description: This white paper was prepared in response to CMS' publication of the Inpatient Prospective Payment System [IPPS] Final Rules for FY 2008 and 2009 which placed additional requirements on hospitals for certain hospital-acquired conditions. This white paper addresses these rulings and the implications for healthcare facilities, including strategies for dealing with challenges created by the rulings.
Introduction

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services issued a final rule on August 1, 2007, which revises the acute care hospital Inpatient Prospective Payment Systems (IPPS). It is probably safe to say that previously most risk management professionals did not fully comprehend the intricacies of the IPPS nor did they deal directly with the IPPS as part of their daily activities. That is not the case today. While the final rule (published in the Federal Register Vol. 72, No. 162 on Wednesday, August 22, 2007) made many significant changes, some of which will be highlighted here, most disquieting to risk management professionals is the provision that prevents Medicare from paying hospitals higher DRG payments for additional costs associated with certain hospital-acquired conditions effective beginning fiscal year 2009 (October 1, 2008).

Subsequent to the rule published in August 2007, additional requirements were added in the FY 2009 IPPS Final Rule released July 31, 2008, and published in the Federal register on August 19, 2008. In particular was the addition of new hospital-acquired conditions [HAC]. In the draft Rules, CMS had recommended and requested public comment on adding nine new hospital-acquired conditions (HACs). The IPPS Final Rule for FY 2009 selected two out of the nine for inclusion, and expanded one previously listed HAC bringing the total number of hospital-acquired conditions up to ten effective October 1, 2008 (the start of CMS fiscal year 2009). Other changes to previously approved HACs include the following:

- An additional code to the HAC for a foreign body retained after surgery to now include an acute reaction to foreign substances accidentally left during a procedure
- Two new ICD-9-CM codes for pressure ulcers stages III and IV.

Background of the IPPS Final Rule

The Inpatient Prospective Payment Systems (IPPS) creates incentives for hospitals to operate efficiently while ensuring that payments adequately compensate hospitals for legitimate costs. The minimization of unnecessary cost is also an objective of the IPPS.1


The Deficit Reduction Act (DRA)

Under the Final Rule, amendments made by the DRA Section 5001(a) were implemented expanding hospital reporting requirements for quality data effective for fiscal year 2007 (beginning October 1, 2007) and subsequent years. The most discussed provisions of the Final Rule centered around Section 5001(c) of the DRA which required the Secretary (of HHS) to select, by October 1, 2007, at least two [hospital-acquired] conditions that meet certain specified criteria that will be subject to a
quality adjustment in DRG payments during fiscal year 2008. The criteria for selection of the two conditions were that they are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present on admission (POA) when reporting payment information for discharges on or after October 1, 2007.

Medicare Improvements and Extension Act under Division B, Title 1 of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA)

Section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classification and relative weights at least annually. Adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

The Medicare Payment Advisory Commission (MedPAC) is required to submit an annual report to Congress on its review and recommendations on Medicare payment policies. The CMS efforts focused on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its “Report to the Congress, Physician-Owned Specialty Hospitals” in March of 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking into account the severity of illness and apply hospital-specific relative value (HSRV) weights to DRGs.

To facilitate those changes, the current CMS–DRG classification system that has been in use for Medicare payments for over 20 years was reformed. The Final Rule for the IPPS revised and expanded the then current CMS-DRG classification system in FY 2007 from 538 DRGs representing 25 major diagnostic categories to the new Medicare Severity–Diagnosis-Related Group (MS-DRG) classification system of 745 DRGs.

Hospital-Acquired Conditions, Including Infections

For discharges occurring on or after October 1, 2008 (FY 2009) hospitals will not receive additional payment for cases in which one of the selected conditions (as seen in Table 1) was not present upon admission or if the documentation is insufficient to determine if the condition was present at the time of admission. The case will be paid as though the secondary diagnosis was not present. As noted in the Regulatory Impact Analysis Section VII A of the Final Rules, these provisions will only apply when the selected condition (as seen in Table 1) is the only secondary diagnosis present on the claim that will lead to a higher payment. If a nonselected (not on the hospital-acquired condition list) secondary diagnosis that leads to the same higher payment is on the claim, the case will continue to be assigned to the higher paying DRG. Patients having one major complication or comorbidity (MCC) or complication or comorbidity (CC) will frequently have additional conditions that also lead to higher payment. Therefore in only a small percentage of cases will the patient have only one secondary diagnosis that would lead to the higher un-reimbursed payment.

While most hospitals have already determined the financial impact of non-payment for hospital-acquired conditions, others that have not done so should determine the impact by reviewing Medicare billing data for FY 2008 (ending September 30, 2008) with DRG codes that would have resulted in a higher payment. The Regulatory Impact Analysis
for hospital-acquired conditions as reported in the FY 2008 Final Rule [at page 48168] estimates savings for the next five fiscal years starting in FY 2009 to be $20 million per year.

In an effort to deliver patient-centered care, most healthcare organizations have developed and implemented comprehensive strategies supported by initiatives in patient safety, quality improvement, and enterprise risk management all with the goal to enhance the quality of care, decrease clinical variability, and promote a safe environment.

There are many strategies that can be implemented to reduce the potential for loss of reimbursement to an organization. The following are just a few of those strategies:

- Prevent hospital-acquired conditions, including infections. The Final Rules offers several suggested evidence-based preventive guidelines (See Table 1 for a list of recommended guidelines). Ensure that all preventive guidelines are in place as recommended or that equivalent protocols are implemented.
- Review physician compliance with adopted protocols, guidelines, and best practices as part of the peer review process. Evaluate on-going clinical competency of individual practitioners rather than the semi-annual review conducted on reappointment.
- Develop preadmission and admitting screening/testing guidelines to determine diagnoses that are present at admission such as pressure ulcers, fractures, burns, etc.
- Educate staff on “present on admission” (POA) coding requirements.
- Report hospital-acquired conditions to others in the organization, such as risk management, patient safety, and quality management. Many of the hospital-acquired conditions may be potentially compensable events (PCEs), generate a claim of negligence or a demand for compensation, and require disclosure to the patient and/or family.
- Understand jurisdictional requirements as they pertain to the mandatory external reporting of adverse medical error. Many of the hospital-acquired conditions listed in Table 1 are also reportable under adverse event reporting statutes in many states.
- Evaluate hospital-acquired conditions and any dollars expended to settle potential claims for mandatory reporting to CMS as July 1, 2008, as required by the Medicare, Medicaid and SCHIP Extension Act of 2007
- Stress the importance of appropriate and adequate documentation. Coders, physicians, and nurses need to fully comprehend the implication of poor documentation on the ability of the organization to code, bill, and collect on diagnoses that are present on admission.
- Consider the development of standardized assessment tools and admission checklist to facilitate the identification of POA secondary diagnoses.
Exclusions to the IPPS Final Rule

The following facilities are excluded from the Inpatient Prospective Payment Systems Final Rule:

- Rehabilitation hospitals and units
- Long-term care hospitals (LTCH)
- Psychiatric hospitals and units
- Children’s hospitals
- Cancer hospitals
- Maryland waiver hospitals
- Religious nonmedical health care institutions

Risk Management Implications and Initiatives

Implications for non-compliance with certain sections of the Final Rules are clear. However, lack of adherence with other sections of the Final Rules are yet to be seen, but clearly include loss of future revenue, additional cost to comply, and negative impact on an organization’s reputation. The impact of the public on the Final Rules will be long-reaching as patients continue to be better informed about hospital-acquired conditions and as health care providers continue in their efforts to communicate with patients and the public in a transparent manner.

It is also important to keep in mind that other payers have initiated nonpayment policies that directly affect the payment for adverse events that occur in the hospital. HealthPartners, a Minneapolis-based health plan, implemented a policy in January 2005 that provides for withholding payments to hospitals for “Never Events.” “Never Events” is the term coined for the original list of 27 events identified by the National Quality Forum (NQF) in 2002 as events that should never occur in a hospital. That list has recently (2006) been revised and expanded and now includes 28 serious reportable events. The Leapfrog Group and other organizations are calling for hospitals to waive billing for hospital-acquired conditions as well. Individual states such as Massachusetts and Minnesota, working with their respective state hospital associations, are following suit in not billing patients and payers for what are considered preventable adverse events. In addition, state Medicaid programs will quickly follow suit as CMS (upon release of the IPPS For FY 2009 on July 31, 2008) sent every state Medicaid director a letter providing information about how states can adopt the same never events practices. They were encouraged to adopt the same non-payment policies outlines in the FY 2009 Final Rule. Nearly twenty states have or are considering methods to eliminate payment for some never events.

So, what does this mean to risk management professionals? What role can and should they take? What initiatives can they implement that will improve patient safety, maintain compliance, enhance fiscal soundness, and add value? What should they do first? Do these questions sound familiar? *If so, you’re not alone.* The following ten steps can be used as a risk management guide for developing strategies to address compliance with the Final Rules:
Ten Steps to Compliance – An ERM Approach

1st - The first step is to understand that compliance with the Final Rules requires a broad approach that encompasses the total organization, in other words, an "enterprise risk management" approach. Enterprise risk management initiatives are not the responsibility of a single person--they require the active participation of many from all levels of the organization.

2nd - To enlist the active involvement of the appropriate people and have a coordinated, planned approach to conserve resources, it is recommended that a multi-disciplinary task force be created to address the requirements of the Final Rules. This task force should represent the various constituents responsible for implementing the various sections of the Final Rules and may include representatives from the medical staff, nursing, infection control, medical records, finance, billing and coding, quality assurance/quality improvement, information technology, patient safety, risk management, patient advocacy, corporate compliance, and legal.

3rd - Once the initial task force members have been assigned and have had the opportunity to meet, each member should read the text of both FY 2008 and FY 2009 Final Rules. X Next, the task force should determine how the work will be divided and assignments made. Individual task force members can be assigned accountability according to areas of expertise or responsibility to lead a designated sub-group (work-group) to focus on specified sections of the Final Rules.

4th – For each section of the Final Rules, assigned work groups should evaluate the financial impact. Determining the potential revenue impact and cost to implement the various sections of the Final Rules should be quantified. In several sections of the Final Rules, CMS analyzed the resource consumption in terms of dollars and time; however with many others sections the cost has not been analyzed.

The risk management professional should consider what impact lost revenue and additional expense related to resource consumption to comply with the Final Rules will have on the total cost of risk. A determination of how the organization will account for waivers, write-offs, and nonpayment of hospital-acquired conditions in costs allocation and claims attribution programs needs to be made as well. A determination as to the impact the MMSEA of 2007 will have on mandatory reporting needs to be made as well; keeping in mind the ability of CMS to levy fines of 1,000 per day/per claims for non-reporting.

5th – The individual work groups should identify any new (or existing) exposures to loss created by the Final Rules, review the efficacy of current loss prevention efforts and recommend initiatives to mitigate new risks. As listed in Table 1, the Final Rules clearly identify currently available preventive standards and guidelines founded on evidence-based medicine that hospitals can adopt to prevent hospital-acquired conditions.

6th - The Task Force reviews the list of exposures and risk mitigation initiatives recommended by the work groups and assists in prioritizing those recommendations considering the following factors:

- Seriousness of the risk
• Availability and cost of necessary resources
• Frequency of the risk
• Availability of loss prevention guidelines
• Time to implement

7th Develop and Implement a communication plan for all affected employees and units.

8th Develop and implement the risk mitigation initiatives recommended.

9th Monitor the effectiveness of all risk mitigation initiatives implemented to ensure compliance with the Final Rules, determine the effectiveness of the risk mitigation initiatives, and determine the financial impact.

10th Continue to monitor and make changes when and wherever necessary.

The Final Rules offer a great deal of background information including comments from the field reviews along with the formal responses from CMS. Part of that background material also highlights the rationale of why each hospital-acquired condition was chosen as well as why other conditions were not selected for inclusion at this time. While it is difficult to determine exactly what conditions will be added/eliminated in subsequent years, the FY 2009 Final Rule identifies additional potential candidate HACs that were suggested through comments. They include the following:

Additional Potential Candidate HACs, Suggested through Comment:
• Surgical site infection following device procedures
• Failure to rescue
• Death or disability associated with drugs, devices, or biologics
• Events on the NQFs list of Serious Reportable Adverse Events, not previously addressed by the HAC payment provision
• Dehydration
• Malnutrition
• Water-borne pathogens, not previously addressed by the HAC payment provision

Other Revisions of Significance to the Risk Management Professional

Several other revisions in the IPPS Final Rule that should be of interest to the risk management professional, but have been overshadowed by the hospital-acquired condition requirements, are:

• Reporting of Quality Measures for FY 2008;
• Changes EMTALA regulations during an declared emergency;
• Disclosure of Physician Ownership in Hospitals and Patient Safety Measures; and
• Development of a Medicare Hospital Value-Based Purchasing Plan.
Quality Measures

Section 5001(a) of the DRA sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. RHQDAPU builds on the ongoing voluntary Hospital Quality Initiative (HQI). Hospitals are required to report quality measures of process, structure, outcomes, patient’s perspective on care, efficiency, and cost of care that relate to services furnished in inpatient settings on the CMS web site. Hospitals submit quality data through the QualityNet Exchange secure Web site (www.qnetexchange.org). Data from this initiative are used to populate the Hospital Compare Web site, www.hospitalcompare.hhs.gov. xi

Effective FY 2007 and for all subsequent fiscal years, the financial penalty for not reporting quality data as provided under section 5001(a) of the DRA is a 2.0 percentage point reduction in the payment update. Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital’s payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase. xii

To be eligible for a full market-basket update in FY 2009 hospitals must report on 30 quality measures. These 30 measures include all of the previously reported measures as well as three additional measures adopted last fall. The new measures include one new outcome measure of pneumonia care and two measures of surgical care, including:

- Pneumonia 30-day mortality;
- Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose; and
- Surgery patients with appropriate hair removal xiii

The FY 2009 final rule also made changes to the RHQDAPU Program effective FY 2010. CMS had originally proposed in the draft Rule for FY 2009 that an additional 43 quality measures be added to the already required 30 bringing the recommended quality measures to be reported up to seventy-three. Because of public comments received and lobby efforts by organizations such as the AHA, CMS elected to only implement 13 of the 43 recommended measures, retiring one quality measure [pneumonia oxygenation assessment], bringing the number of reportable quality measures for FY 2010 [effective October 1, 2009] to 42. The 13 new measures include the following:

- Surgical Care Improvement Project (SCIP)
  - Surgery patients on a beta-blocker prior to arrival who received beta blocker during the perioperative period
- Nursing Sensitive Measures
  - Failure to rescue
- Readmission Measures
  - Heart failure 30-day risk standardized readmission measure (Medicare only)
- AHRQ Inpatient Quality Indicators [IQI]:
  - Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
  - Hip fracture mortality rate
• AHRQ Patient Safety Indicators [PSI]
  - Death among surgical patients with treatable complications
  - Iatrogenic pneumothorax, adult
  - Postoperative wound dehiscence
  - Accidental puncture or laceration

• AHQ IQI Composite Measures
  - Mortality for selected medical conditions (composite)
  - Mortality for selected surgical procedures (composite)
  - Complication/patient safety for selected indicators (composite)

• Cardiac Surgery Measures
  - Participation in a systematic database for cardiac surgery

Note: Two additional measures for heart attack & pneumonia are expected to be endorsed by the National Quality Forum in the fall 2009 with CMS adoption in 2010.

While the IPPS Final Rule for FY 2009 addressed other changes too numerous to discuss in this update, there are a few additional clarifications that deserve mentioning. They include the following:

• Clarification that a hospital’s EMTALA obligation ends with a patient's admission.
• Approval for hospital to meet their on-call obligation through participation in a “community-call plan.”
  - Community call allows for a group of self-selected hospitals in a self-designated region to collectively provide on-call services.
  - Community call allows for a specific hospital to be the designated on-call facility for all of the hospitals involved for a specified service, specified time, or both.

• The new “community-call” regulations require a formal plan that includes the following elements:
  - Clear delineation of responsibilities for each participating hospital
  - A description of geographical area covered by the plan
  - Representative’s signature of participating hospital
  - Assurances local/regional EMS protocols include information on community on-call arrangements
  - Statement reaffirming the obligation of each participant to meet EMTALA obligations for medical screening exam [MSE] and stabilizing treatment within its capacity, and comply with transfer requirements
  - Annual assessment of the plan by hospital participants

Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA regulations at 42 CFR 489.24 were amended to reflect changes made by the Pandemic and All-Hazards Preparedness Act, Pub. L. 109-417 section 302(b) and to ensure that the Final Rule accurately reflects section 1135 of the Social Security Act. The proposed revisions to §489.24 were adopted as final, without modification, and “specify that the sanctions that do not apply are those for either the inappropriate transfer of an individual who has not been stabilized, or those for the direction or relocation of an individual to receive medical screening at an alternate location.”
“...Waiver of these sanctions for EMTALA violations is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the duration of the waiver will be determined in accordance with section 1135(e) of the Act as it applies to public health emergencies.”

Disclosure of Physician Ownership in Hospitals and Patient Safety Measures

In the furtherance of patient-centered care, disclosure, transparency, and patient safety, it is in the interest of patients who are provided services by the hospital to be made aware of certain issues concerning the availability of physicians for inpatient emergencies and any ownership interest physicians have in the hospital where their patients are receiving services.

Physician Ownership

Section 489.20(u)(1) requires physician-owned hospitals, as defined in § 489.3, to furnish written notice to all patients that the hospital is a physician-owned hospital and that the list of physician owners is available upon request. The notice must be furnished at the beginning of their hospital stay or outpatient visit.

In order to enforce these proposed requirements, § 489.12 is amended to permit CMS to deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital. In addition, § 489.53 is amended to permit CMS to terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with the requirements of § 489.20(u).

FY 2009 IPPS Final Rule clarifies disclosure requirements to include an immediate family member of a physician who holds an ownership or investment interest

Exemptions:
- No physician owners who refer patients to the hospital,
- No referring physicians who have an immediate family member with an ownership or investment interest in the hospital

Patient Safety Measures

42 CFR 489.20(v) requires that hospitals and critical access hospitals (CAHs) furnish all patients written notice at the beginning of their hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, and to describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital.

-- Development of the Medicare Hospital Value-Based Purchasing Plan

Section 5001(b) of the Deficit Reduction Act of 2005 (DRA) requires the Secretary of Health and Human Services to “develop a plan to implement a value-based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009.” Congress specified that the plan include consideration of the following issues:
• The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.
• The reporting, collection, and validation of quality data.
• The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments.
• The disclosure of information on hospital performance.

Conclusion

The revised IPPS as seen in the Final Rules released in August 2007 and July 2008 supports a wide variety of views and opinions. Many healthcare stakeholders offer differing opinions as to its value, ability to implement, and fairness. Patients, clinical practitioners, healthcare administrators, payers, regulators, to name a few, all have opinions, many of which differ. Even within the healthcare facility there are wide differences in opinions. The quality assurance and patient safety professional may say, "Finally! Now we’ll get more resources to implement much needed safety strategies," while the practitioner may be fearful of the time and extra paperwork necessary to document secondary diagnoses POA. To comprehend the details and full ramifications of the Final Rules on the organization will take the risk management professional time and the assistance of many others within the organization.

The Final Rules mandate that hospitals be accountable, fiscally prudent, patient-centered, and responsible providers of care. Healthcare providers can no longer offer rhetoric to evidence-based practice. They must translate and implement that knowledge into everyday practice. While this should not be a new charge for hospitals, it nonetheless offers new challenges and opportunities. How they manage these changes will dictate how successful they will be in the future.

Submitted by:
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Senior Vice President
Aon Healthcare
<table>
<thead>
<tr>
<th>Hospital-Acquired Conditions</th>
<th>Medicare Data—Number of Cases &amp; Average Charge for Hospital Stay</th>
<th>Key Guideline for Prevention/Reduction</th>
<th>NQF Serious Reportable Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Foreign object retained after surgery</td>
<td>750 / $63,631</td>
<td>AHRQ’s “Guide to Patient Safety Indicators”</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Air Embolism</td>
<td>57 / $71,636</td>
<td>AHRQ’s “Guide to Patient Safety Indicators”</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Blood Incompatibility</td>
<td>24 / $50,455</td>
<td>AHRQ’s Patient Safety Indicators”</td>
<td>Yes</td>
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<tr>
<td>5. Pressure ulcers stages III &amp; IV</td>
<td>257,412 / $43,180</td>
<td>AHRQ’s “Pressure Ulcers in Adults: Prediction and Prevention” and the National Pressure Ulcer Advisory Panel</td>
<td>Yes (for stage 3 or 4)</td>
</tr>
<tr>
<td>b. Certain orthopedic surgeries</td>
<td>b. 269 / $148,172</td>
<td></td>
<td></td>
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<tr>
<td>c. Bariatric surgery for obesity</td>
<td>c. 37 / $233,614</td>
<td></td>
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<tr>
<td>10. Certain manifestations of poor control of blood sugar levels to include—</td>
<td>a. Diabetic ketoacidosis</td>
<td>a. 11,469 / $42,974</td>
<td>Available at following the Web sites: [<a href="http://www.diabetes.org/uedocument">http://www.diabetes.org/uedocument</a> s/inpatientDMGlycemicControlPositionStmt02.01.06.REV.pdf] [<a href="http://www.hospitalmedicine.org/ResourceRoomRedesign/GlycemicControlI.cfm">http://www.hospitalmedicine.org/ResourceRoomRedesign/GlycemicControlI.cfm</a>]</td>
</tr>
<tr>
<td>b. Nonketotic hyperosmolar coma</td>
<td>b. 3,248 / $35,215</td>
<td></td>
<td></td>
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<tr>
<td>c. Hypoglycemic coma</td>
<td>c. 212 / $36,581</td>
<td></td>
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<tr>
<td>d. Secondary diabetes with ketoacidosis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>e. Secondary diabetes with hypersmolarity</td>
<td></td>
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Source: Department of Health and Human Services Centers for Medicare & Medicaid Services, 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule and Inpatient Prospective Payment System [IPPS] FY 2009 Update published August 19, 2008 in the Federal register
### Glossary of Terms

<table>
<thead>
<tr>
<th>(a) Table 2</th>
<th><strong>Glossary of Terms</strong></th>
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<tbody>
<tr>
<td>(b) AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<tr>
<td>(c) CABG</td>
<td>Coronary artery bypass graft surgery</td>
</tr>
<tr>
<td>(d) CAH</td>
<td>Critical access hospital</td>
</tr>
<tr>
<td>(e) CC</td>
<td>Complication or comorbidity</td>
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<tr>
<td>(f) CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>(g) CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>(h) DRA</td>
<td>Deficit Reduction Act of 2005 (Pub. L. 109-171) and the</td>
</tr>
<tr>
<td>(i) DRG</td>
<td>Diagnosis-related group</td>
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<tr>
<td>(k) FY</td>
<td>Fiscal Year For CMS this begins October 1 of each year. As example, FY 2008 if from October 1, 2007 through September 30, 2008.</td>
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<tr>
<td>(l) HQI</td>
<td>Hospital Quality Initiative</td>
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<td>(m) ICD-9-CM</td>
<td>International Classification of Diseases, Ninth Revision, Clinical Modification</td>
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<tr>
<td>(n) IPF</td>
<td>Inpatient psychiatric facility</td>
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<tr>
<td>(o) IPPS</td>
<td>Inpatient Prospective payment System</td>
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<tr>
<td>(p) NQF</td>
<td>National Quality Forum</td>
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<tr>
<td>(q) MCC</td>
<td>Major complication or comorbidity</td>
</tr>
<tr>
<td>(r) MDC</td>
<td>Major Diagnostic Categories</td>
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<tr>
<td>(s) MIEA-TRHCA</td>
<td>Medicare Improvement and Extension Act under Division B, Title 1 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-417).</td>
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<tr>
<td>(t) MS-DRG</td>
<td>Medicare Severity-Diagnostic Relative Group</td>
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<tr>
<td>(u) NQF</td>
<td>National Quality Forum</td>
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<tr>
<td>(v) POA</td>
<td>Present on admission</td>
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<tr>
<td>(w) RHQDAPU</td>
<td>Reporting Hospital Quality Data for Annual Payment Update</td>
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</table>
Endnotes

i Federal Register Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations pp 48157.


vii As an example: Hospitals that fail to notify patients of physician ownership can permit CMS to terminate the provider agreement or to deny a provider agreement to a hospital that does not have a procedure in place to notify patients of physician ownership in the hospital. Financial penalties apply to those hospitals that elect not to report the required 27 quality measures in FY 2008.

viii CMS Press Release Thursday, July 31, 2008 “Medicare and Medicaid Move Aggressively To Encourage Greater Patient Safety In Hospitals And Reduce Never Events.”

ix “Enterprise Risk Management (ERM) is an on-going business decision-making process instituted and supported by the healthcare organization's board of directors, executive administration and medical staff leadership. Recognizing the synergistic effect of risk across the continuum of care, the goal of ERM is to assist the organization realize its’ mission by reducing uncertainty and process variability, promoting patient safety and maximizing the return on investment (ROI) by asset preservation, and the recognition of actionable risk opportunities. Carroll R December 2007.

x The FY 2008 Final Rule as published in the Federal Register on August 22, 2007, is 1047 pages in length, however, just over 300 pages are narrative; the remaining pages are tables representing supporting data.


xii Federal Register Vol. 72, No. 162 / Wednesday, August 22, 2007, Rules and Regulations pp 47345.


CMS estimates of Medicare cases and average charge for hospital stays in FY 2006. A case represents a patient discharge identified from the MedPAR database that met the associated HAC diagnosis/procedure criteria (a secondary diagnosis on the HAC list and, where appropriate, a procedure code described in conjunction with a specific HAC). The standardized charge is the total charge for a patient discharge record based on the CMS standardization file. The average standardized charge for the HAC is the average charge for all patient discharge records that met the associated HAC criteria.


The number of cases of pressure ulcers reflects CC/MCC assignments for codes 707.00 through 707.07 and 707.09, which were reported until October 1, 2008. New MCC codes 707.23 and 707.24 were implemented on October 1, 2008. Prevention guidelines available at: [http://www.npuap.org/position1.html] and [http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409].

CDC reports 248,678 central-line associated bloodstream infections per year. However CMS was unable to identify Medicare cost data as there is currently no unique existing ICD-9-CM code.

CDC guidelines are available at [http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html.]

Further information can be found at [http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html].

Final rule pp 47215–No dollar estimates given - number is an aggregate number for all ICD-9 code for fractures and other traumatic injuries in the categories listed.

Medicare data are not available for FY 2007 because ICD-9-CM codes are not effective until October 1, 2008.