Change is a constant in the documentation and coding of diagnoses and procedures for inpatient hospital stays. October 1 is an important time to evaluate coding changes because it’s when CMS’ annual update to the inpatient prospective payment system (MS-DRGs) takes effect. Each year, after analyzing the previous year’s Medicare claims data, CMS updates the DRGs to better reflect resource utilization patterns. To keep the changes budget-neutral, some DRG payments are increased and others are decreased. The overall changes will affect hospitals differently depending on their case-mix.

The box below demonstrates some examples of CMS’ annual payment adjustments for federal fiscal year 2010. Payments are calculated with a hospital-specific rate of $5,500.

Before publication of the 2010 Final Rule on Aug. 28, 2009, CMS had publicized a plan to reduce payments as a behavioral adjustment (penalty) for improved documentation and coding. However, the agency deferred the payment reduction until 2011 to allow more time for data analysis.

At the recommendation of the Agency for Healthcare Research and Quality, CMS added a new ICD-9-CM code to report a diagnosis of chronic pulmonary embolism and other ICD-9-CM codes to distinguish among acute, chronic and “history of” venous embolism or thrombosis. Physician documentation of venous thrombosis will be coded as acute if not further specified. “Chronic venous thrombosis or embolus (specify vessel)” will be coded when documented by the physician if the patient is still receiving treatment for the condition. “History of” venous embolism or thrombosis is reported with a V code representing a personal history of this condition.

The new codes for chronic pulmonary embolus and chronic venous thrombosis/embolus are counted as comorbidities under the MS-DRGs. The “history of” code does not count as a comorbidity; therefore, it is important for the physician to differentiate between chronic and “history of” in the medical record. Remember that CMS is considering new quality measures for venous thromboembolism, so getting the documentation right now is good preparation for the future.

A significant portion of the 2010 Final Rule is devoted to discussion of CMS’ Value-Based Purchasing Initiative and the expansion of its objectives over the next few years. In 2009, a reported $21 million was saved through payment penalties for the 11 hospital-acquired conditions considered to be reasonably preventable (see sidebar on the following page). No new “reasonably preventable” conditions were added to the payment penalty list for 2010, but additional conditions are planned for 2011. The following are being considered:

- ventilator-associated pneumonia,
- failure to rescue,
- surgical site infection following implantation of devices,
- Clostridium difficile-associated disease, and
- malnutrition.

### Examples of annual payment adjustments

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Title</th>
<th>Federal fiscal year 2009</th>
<th>Federal fiscal year 2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>190</td>
<td>COPD with major complication/comorbidity</td>
<td>$7,166</td>
<td>$6,605</td>
<td>−$561.00</td>
</tr>
<tr>
<td>239</td>
<td>Amputation for circulatory system disorder except upper limb and toe with major complication/comorbidity</td>
<td>$24,777</td>
<td>$25,966</td>
<td>$1,189.00</td>
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</tbody>
</table>