c. Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims

We have received repeated requests from the hospital community to process all 25 diagnosis codes and 25 procedure codes submitted on electronic hospital inpatient claims. Hospitals can submit up to 25 diagnoses and 25 procedures; however, CMS' current system limitations allow for the processing of only the first 9 diagnoses and 6 procedures. While CMS accepts all 25 diagnoses and 25 procedures submitted on the claims, we do not process all of the codes because of these system limitations. We recognize that much valuable information is lost by not processing the additional diagnosis and procedure codes that are reported by hospitals.

We responded to hospitals' requests that we process up to 25 diagnosis codes and 25 procedure codes in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43798). In that final rule, we referred readers to the ICD–10 final rule (74 FR 3328 through 3362) where we discuss the updating of Medicare systems prior to the implementation of ICD–10 on October 1, 2013. We mentioned that part of the system updates in preparation for ICD–10 is the "expansion of our ability to process more diagnosis and procedure codes." In the FY 2009 IPPS final rule (73 FR 48433 through 48444), we also responded to multiple requests to increase the number of codes processed from 9 diagnosis and 6 procedure codes to 25 diagnosis and 25 procedure codes.

CMS is currently undergoing extensive system updates as part of the move to 5010, which includes the ability to accept ICD–10 codes. This complicated transition involves converting many internal systems prior to October 1, 2013, when ICD–10 will be implemented. One important step in this planned conversion process is the expansion of our ability to process additional diagnosis and procedure codes. We are currently planning to complete the expansion of this internal system capability so that we are able to process up to 25 diagnoses and 25 procedures on hospital inpatient claims as part of the HIPPA ASC X12 Technical Reports Type 3, Version 005010 (Version 5010) standards system update. CMS will be able to process up to 25 diagnosis codes and 25 procedure codes when received on the 5010 format starting on January 1, 2011. We recognize the value of the additional information provided by this coded data for multiple uses such as for payment, quality measures, outcome analysis, and other important uses. We will continue to pursue this additional processing capacity as aggressively as possible in response to the multiple requests from the hospital industry. We appreciate the support of the health care community for this extensive system update process that will allow us to process more of this important data. Therefore, for claims submitted on the 5010 format beginning January 1, 2011, we will increase the capacity to process diagnosis and procedure codes on hospital inpatient claims from the current 9 diagnoses and 6 procedures up to 25 diagnoses and 25 procedures.

H. Recalibration of MS–DRG Weights

In developing the proposed FY 2011 system of weights, we used two data sources: Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2009 MedPAR data used in this proposed rule include discharges occurring on October 1, 2008, through September 30, 2009, based on bills received by CMS through December 31, 2009, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2009 MedPAR file used in calculating the proposed relative weights includes data for approximately 11,004,046 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2008 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2007, and before October 1, 2008), which represents the most recent full set of cost report data available. We used the December 31, 2009 update of the HCRIS cost report files for FY 2008 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2009 MedPAR claims data and FY 2008 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the proposed FY 2011 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this proposed rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2009 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each MS–DRG and before eliminating statistical outliers.
- Claims with total charges or total lengths of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.
- At least 96.1 percent of the providers in the MedPAR file had charges for 10 of the 15 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 15 cost centers were deleted.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each MS–DRG.
- Effective October 1, 2008, because hospital inpatient claims include a POA indicator field for each diagnosis present on the claim, only for purposes of relative weight-setting, the POA indicator field was reset to "Y" for "Yes" for all claims that otherwise have an "N" (No) or a "U" (documentation insufficient to determine if the condition was present at the time of inpatient admission) in the POA field.

Under current payment policy, the presence of specific HAC codes, as indicated by the POA field values, can generate a lower payment for the claim.