



In This Issue:

❑ CMS FY 2009 IPPS Proposed Rule

...MS-DRG System Transition Complete

...CMS Continued Focus on Hospital Quality

❑ Did You Know?

...A/B MAC Jurisdiction 7 Awarded

This information is provided as a service to assist hospitals and other providers of blood products and blood services. Providers are responsible for accurately coding and billing for services rendered as appropriate to their situation and payer-specific requirements. Please contact your blood center with any questions pertaining to this newsletter.

Proposed Changes to the 2009 Inpatient Prospective Payment System

On April 14, 2008, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2009 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule. In FY 2007, CMS began a three-year phase-in of setting Medicare-Severity Diagnosis Related Group (MS-DRG) relative weights based on costs rather than charges. In the proposed rule, CMS provides updated weights for the MS-DRGs. FY 2009 marks the end of the transition to the new MS-DRG system. Beginning October 1, 2008, DRG weights will be fully adjusted for severity and calculated solely on cost-based relative weights.

CMS also addresses in its proposed rule the issue of charge compression, which is the tendency of hospitals to mark up less costly devices and services by a higher proportion than they mark up high-cost devices and services. CMS is proposing to address charge compression issues in the calculation of MS-DRG relative weights for devices and implants by setting up a separate cost center to distinguish devices and implants from other medical supplies, such as blood and blood services. These less costly services tend to be marked up by a higher proportion than higher cost services and devices.

The proposed rule also confirms CMS's commitment to quality and the continuation of two significant initiatives to improve patient care in hospitals. Under the Hospital Acquired Condition (HAC) initiative, hospitals are required to report if specific conditions are present upon admission. For a condition to be selected as a HAC, it must (a) be 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) be reasonably preventable through the application of evidence-based guidelines.

On October 1, 2007, hospitals were required to report whether diagnosis codes were present on admission when submitting Medicare claims. This allows Medicare to verify whether payment should be made for those diagnoses that qualify as HACs.

Eight conditions (including blood incompatibility) were selected as HACs and finalized in the FY 2008 final rule, and nine conditions were proposed in the FY 2009 proposed rule. Payment implications will begin October 1, 2008, for the eight conditions selected in the FY 2008 final rule and any of the nine proposed conditions that are selected in the FY 2009 final rule. Medicare will not pay more for these conditions if they were acquired in the hospital and were reasonably preventable through the application of evidence-based guidelines. Additional information on the HAC initiative and POA indicators can be found at www.cms.hhs.gov/hospitalacqcond.

CMS also is proposing an expansion of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), which reduces the amount a hospital is paid if it does not voluntarily report on standardized quality measures. Hospitals that submit specified quality data will receive the full market basket increase (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients) of 3.0% for FY 2009, while hospitals that do not report this information will be subject to a 2.0% reduction to the update, lowering the increase to 1.0%.

Hospitals currently are required to report 30 quality measures on their claims for Medicare inpatient services to qualify for a full update in FY 2009. CMS proposes adding 43 new measures and retiring 1 measure for the FY 2009 reporting period, to receive the full update in FY 2010.

Quality data on participating hospitals is available on the CMS Website at www.hospitalcompare.hhs.gov. Additional information on the hospital quality initiative is available at www.cms.hhs.gov/HospitalQualityInits. Comments on the changes addressed in the FY 2009 IPPS rule were accepted through June 13, 2008. The final rule is expected to be released on or before August 1, 2008.

FDA Identifies Contaminant in Blood-Thinning Drug

On January 25, 2008, Baxter Healthcare Corporation recalled multi-dose and single-dose vials of heparin sodium for injection as well as HEP-LOCK heparin flush products, after receiving an unusual increase in reports of adverse events, including deaths. Some reported reactions included nausea, vomiting, shortness of breath, and a severe drop in blood pressure. Patients who were given higher dosages of the contaminated heparin experienced more severe reactions. The United States (US) Food and Drug Administration (FDA) issued a public health advisory on February 11, 2008, to alert the public about reports of serious adverse events in patients who received the contaminated product and to recommend measures that may help to minimize risks, if the use of the product proved medically necessary.

Initial investigation suggested that the contaminated heparin contained active pharmaceutical ingredient traced from China. In late March, FDA officials identified the contaminant as oversulfated chondroitin sulfate. On April 21, 2008, after further investigation and laboratory analysis, FDA officials were able to establish a link between oversulfated chondroitin sulfate and the serious adverse events witnessed in patients given heparin.

Investigation allowed officials to trace the contaminant to 12 different Chinese companies, including one supplier, Scientific Protein Labs, which supplied Baxter with the contaminated heparin. The contaminant also has been found in heparin batches shipped to 11 countries.

As FDA proceeds with its investigation, it continues to work independently and in collaboration with the Centers for Disease Control and Prevention, Baxter, and other private and public entities in monitoring the situation, and has contacted regulators around the world to determine whether similar events have been seen in other countries. For more information on the ongoing investigation, visit the FDA's Website, at <http://www.fda.gov/cder/drug/infopage/heparin/default.htm>.

Hospital Charged with Submitting False Claims

Hartford Hospital will pay the Medicare program \$788,960 to settle allegations that it overcharged the government for certain cancer treatments, including blood transfusion services, from August 2000 to December 2003. According to the settlement agreement, the hospital billed multiple units for blood transfusion services when Medicare allowed payment for only one unit per patient per day. Hartford Hospital blamed the over-billing on an "unintentional oversight," and stated that the hospital was not up to speed on new billing requirements implemented by CMS during that time. The hospital did not admit liability and agreed to the settlement to avoid litigation. According to *The Hartford Courant*, Hartford Hospital was the fourth hospital in Connecticut to settle charges based on this practice.

NPI Requirement Now in Effect

Effective May 23, 2008, physicians must use their National Provider Identifiers (NPIs) when filing electronic claims to Medicare, most Medicaid agencies, and some large private payers. The requirement stems from the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which included a series of provisions that required the Department of Health and Human Services (HHS) to adopt standards for electronic health care transactions and code sets and identifiers to be used in those transactions. Originally, the provisions were set to go into effect May 23, 2007, but in response to industry concerns, CMS postponed the compliance requirement date by one year, and waived penalties for entities that established contingency plans and made reasonable efforts to become NPI-compliant.

The NPI is a 10-digit, intelligence-free numeric identifier. Unlike legacy identifiers, such as tax identification numbers, NPI numbers do not carry additional information about healthcare providers, such as the state in which they live or their medical specialty. For all primary and secondary provider fields, only the NPI will be accepted and must be included on all HIPAA electronic transactions.

For additional information on the NPI requirement, visit: http://www.cms.hhs.gov/NationalProviderStand/01_Overview.asp#TopOfPage.

Did you know...that CMS selected Pinnacle as the A/B MAC Contractor for J7?

On June 11, 2008, CMS announced that Pinnacle Business Solutions, Inc. (PBSI), will serve as the A/B Medicare Administrative Contractor (MAC) for Jurisdiction 7, which includes Louisiana, Arkansas, and Mississippi. PBSI will begin implementation activities immediately and will assume full responsibility for its claims processing work no later than February 2009. PBSI is the eighth A/B MAC to be awarded by CMS. By 2011, a total of 15 new A/B MAC contractors will assume claims processing responsibilities for every state and the District of Columbia.