2020 IPPS proposed rule brings potential MS-DRG changes

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At 520 pages, the fiscal year 2020 IPPS proposed rule is a serious read, and an article claiming to give you the highlights can offer only the highlights of the highlights. This article will focus on some noteworthy proposed changes to MS-DRG assignment for the coming fiscal year.

If there is a theme to this year's proposed MS-DRG changes, it is "ICD-10 data." Now that two years' worth of MedPAR data, coded in ICD-10 after the code freeze ended, is available for analysis, CMS is using it to inform its proposed changes to the MS-DRGs.

This year's changes include a fresh look at the ICD-10-CM codes on the MCC and CC lists, a review of the "Unrelated OR DRGs" 981-983 and 987-989, and surgical DRG modifications that use the structure of ICD-10-PCS, rather than the DRG assignment inherited from the ICD-9-CM-based version of the MS-DRGs.

Changes to MCC and CC designation

The last time CMS conducted a comprehensive review of the MCC and CC severity level designation was 12 years ago, when CMS transitioned from DRGs to MS-DRGs for FY 2008. Given the transition to ICD-10-CM and the significant changes to diagnosis codes, CMS said, it was time to do the analysis again.

The analysis consists of a simulation that takes all ICD-10-CM codes assigned as secondary diagnoses in the MedPAR claims data and assigns each code a "C" value. The C value places each ICD-10-CM code on a number line between somewhere 0 and 4. The value indicates whether its current MCC, CC, or non-CC designation is appropriate—and if not, whether the code should be moved from the CC to the MCC list, moved from the MCC to CC list, or should not have a severity level designation at all.

CMS' clinical advisors use the results of the simulation combined with their clinical judgment to decide to what degree a particular secondary diagnosis is likely to impact resource use and recommend changes accordingly.

The results of the recommended changes for FY 2020 are summarized in the proposed rule, and each proposed change is listed in a separate Excel file available for download. If the proposed changes from this year's comprehensive review go into effect, the number of codes designated MCC will decrease from 3,244 codes to 3,099 codes, and the number of codes designated CC will decrease from 14,528 codes to 13,691 codes.

By applying the proposed changes to the FY 2018 MedPAR data, CMS estimates the overall percentage of cases with one or more CC/MCC present on the record would decrease by about 5 percent, from the current level of 81.5 of all records containing at least one CC or MCC, to 76.6 percent. Below are a few examples of proposed changes:

- More than half of the codes on the list of proposed changes are from the Neoplasm chapter, and CMS proposed to change their severity level designation from CC to non-CC. The reason given is that the simulation showed that taken as a group, the neoplasm codes when listed as a secondary diagnosis were not likely to significantly impact resource use. The proposal goes on to explain that since the neoplasm is not the reason for admission (not listed as the principal diagnosis), it makes clinical sense that it does not significantly impact resource use for that hospital stay.
- 150 ICD-10-CM pressure ulcer codes specified as stage 3 or stage 4 are proposed for severity level change from MCC to CC. CMS explained that the resource use appears to be largely consistent with a CC level, regardless of the stage of the ulcer, because the underlying illness or debility of the patient that predisposes the person to pressure ulcer is the primary driver of resource use, and further, the presence of any pressure ulcer is a more important indication of resource use than the stage of the ulcer.
- CMS proposed changing the severity level designation from MCC to CC for several codes specifying acute myocardial infarction (MI) in categories I21 and I22.

Review of 'Unrelated OR DRG' assignments

CMS annually reviews what are informally called the "unrelated OR DRGs" (MS-DRGs 981-983 and 987-989) to look for combinations of diagnosis and procedure codes that are likely to be related, and therefore the procedure code triggering the unrelated DRG assignment can be assigned to a related surgical MS-DRG—a surgical DRG in the MDC where the diagnosis is found.

This year, with the benefit of ICD-10 coded data, CMS was able to uncover some interesting combinations and propose solutions:

- Principal diagnosis of Gastrointestinal Stromal Tumor (GIST) paired with a procedure code for open excision of stomach—This code combination triggers the unrelated OR DRG because the diagnosis is currently assigned to MDC 8 (Diseases of the musculoskeletal system and connective tissue). GIST neoplasms are currently assigned to the musculoskeletal MDC because stromal tumors are classified in ICD-10-CM as connective tissue neoplasms. CMS proposes to resolve the issue by moving the diagnosis codes to MDC 6 (Diseases of the digestive system). where they are more clinically at home, and so future claims containing this principal diagnosis and a digestive system procedure will no longer trigger an unrelated OR DRG.
- Principal diagnosis of pressure ulcers stage 3 and 4 paired with procedure codes for excision of bone—Procedures describing open excision of the sacrum, coccyx, and pelvic bones were assigned to an unrelated OR DRG when paired with a principal diagnosis of pressure ulcer,

because pressure ulcer codes are assigned to MDC 9 (Diseases of the skin, subcutaneous tissue, and breast). Since the procedure codes are used to capture debridement of a pressure ulcer that extends down to bone, these procedures are related to the principal diagnosis. CMS proposes to assign the procedure codes to a surgical in MDC 9, MS-DRGs 579-581 (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC, and without CC/MCC, respectively).

Below are a few other proposed MS-DRG changes of interest:

- Peripheral extracorporeal membrane oxygenation (ECMO) — New ICD-10-PCS codes for ECMO were added in the 2019 update. They specified "peripheral ECMO," which is ECMO using peripheral vessels for cannulation. and "central ECMO," meaning open chest cannulation via sternotomy. Before that, there was only one code for ECMO and it was classified as pre-MDC. Instead of being classified pre-MDC, the new peripheral ECMO codes were assigned to various DRGs corresponding to the reason the ECMO was initiated—respiratory system diagnosis, heart failure, unexplained cardiac arrest, or sepsis. CMS received public comment contesting this DRG assignment. Stakeholders maintained that most of the costs of inpatient hospital stays involving ECMO stem from the patient's severity of illness, and do not depend on the method of cannulation. CMS reconsidered its earlier position and agreed with stakeholder assessment that the method of cannulation should not determine DRG assignment. For 2020, the peripheral ECMO codes are assigned pre-MDC.
- Pulmonary embolism with acute cor pulmonale—The ICD-10-CM codes for pulmonary embolism with acute cor pulmonale in category I26 were reassigned to a different MS-DRG, based on severity of illness. These codes were designated "PDX is its own MCC" in previous versions of ICD-10 MS-DRGs. This designation was discontinued last year, because according to CMS it was an artifact of ICD-9-CM MS-DRG replication process, and there were existing mechanisms within the DRGs to account for ICD-10-CM codes that reflect higher costs. The ICD-10 data show that average costs for patients with pulmonary embolism and acute cor pulmonale are closer to the average costs in MS-DRG 175 (Pulmonary Embolism with MCC) than the average costs in MS-DRG 176 (Pulmonary Embolism without MCC). So here is the first example where CMS is using "the existing mechanism." They are proposing to rename DRG 175 "Pulmonary Embolism with MCC or Acute Cor Pulmonale."
- Transcatheter mitral valve repair with implant—CMS received two previous requests (FY 2015 and FY 2017) from the manufacturer of the MitraClip® to change the MS-DRG assignment for the procedure code that represents their technology, transcather mitral valve repair (TMVR). TMVR is coded as "Supplement mitral valve with synthetic substitute, percutaneous approach" in ICD-10-PCS. They also asked CMS to consider reclassifying other endovascular cardiac valve repair codes. CMS conducted a systematic review of DRG assignment for this subset of ICD-10 procedure codes. After reviewing the data and discussing the options in detail, they are proposing to group the endovascular procedure codes that use a device to reinforce or augment a heart valve (i.e., root operation Supplement) with the endovascular valve replacement procedures, and to rename MS-DRGs

266 and 267 from Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC/without MCC, respectively.

CMS is also proposing to create two new DRGs for all other transcatheter cardiac procedures—not valve replacement and not valve supplement—procedures such as dilation of a stenotic valve, or excision/destruction of a lesion on a valve. The proposed numbers and titles of the new DRGs are 319 and 320 (fairly low in the hierarchy of the cardiac procedure MS-DRGs) and are titled "Other Endovascular Cardiac Valve Procedures with MCC/without MCC," respectively.

Editor's note: Butler is the clinical research manager at 3M Health Information Systems. Opinions expressed do not necessarily reflect those of HCPro, ACDIS, or any of its subsidiaries. For questions, contact associate editor Sarah Gould at sgould@hcpro.com.