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3M Quality Webinar Series

A close look at the 2020 IPPS Final Rule

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Jared Welcome to today's 3M Health Information Systems webinar. My name is Jared, and I'll be your host. In today's webinar, we'll take a close look at the 2020 IPPS final rule. We encourage you to ask questions throughout the presentation. You can do this by using the questions feature in the web meeting controls which is located in the lower right portion of your screen. We are recording today's presentation and a webinar archive will be available so look out for an email within the next week that will include the archive. A PDF that contains all the presentation slides is available for you to download, and that's located in the handouts section of your web meeting controls. We'll also provide a certificate of attendance to webinar attendees, and that will be emailed to you upon the completion of this webinar.

Today's presenters are Audrey Howard and Cheryl Manchenton. Audrey has over 25 years of experience in health information management and is a senior inpatient consultant for 3M Health Information Systems. Cheryl has more than 24 years of experience in clinical documentation improvement and is also a senior inpatient consultant for 3M Health Information Systems. Audrey and Cheryl, I know we're all excited to get started, so I'll turn the presentation over to you.

Cheryl Great. Thank you, Jared. As we get started, welcome everyone. If you could serve up our first polling question, please.

Jared Okay. Just launched.

Cheryl Great. Miss Audrey, would you like to review our objective today?

Audrey Yes. As you are answering this polling question, just to let you know that by the end of today's presentation you will have a better understanding of some of the new diagnosis codes and how they impact quality, and you will also have a better understanding of the final rule changes from the Centers for Medicare and Medicaid Services, or CMS, as it's related to quality. Jared, how are we on those responses coming in?

Jared Yes. I'm going to close it out here and share the responses. We have had, we had 78% said yes, six percent said no, and 15% said I don't know.

Cheryl Great. Thank you, Jared. To the 78%, that's awesome. I'm glad that you're looking to see not only what are the codes but what do they do. Secondly, for the 15% that I don't know, that's a good question to ask your organization, in other words ask the right questions and other than joining us every year, make sure that your organization has thought through that and is studying it. We don't want to assume that everybody has done their own homework shall we say. For the six percent, I strongly encourage you, but I'm very pleased with that 78% and I think it really is a measure of where we are that we're really having to focus on quality. I think if we'd asked this question 10 years ago, I think you'd agree we'd get a very different, it'd be a lot less people looking at the changes and the impact on quality.

Audrey I absolutely agree with you on that. We have had a lot of focus being on quality, and that's what we really are going to be focusing on today. Let's begin our discussion with some of the new coding updates that become effective on October 1st, 2019 and how they may impact the quality initiative.

Our first one that we're going to be talking about today is Type Two MIs. There was a revised instructional note under code I21.A1 for myocardial infarction type two. Prior to this change, this was a code also note, which did not delineate sequencing. Now that this is a code first the underlying cause note, it means that the underlying condition causing the type two AMI must be sequenced first followed by the I21.A1 code. Conditions such as anemia, COPD, or paroxysmal tachycardia would be coded first, followed by the type two AMI code as a secondary diagnosis.

Audrey continued

In addition to the coding guideline was updated to support the instructional note revision in ICD-10-CM. What this guideline is saying is that when a patient is diagnosed with a type two MI, the underlying cause is coded first. The sentence regarding sequencing being dependent on circumstances of admission was deleted. For the purpose of today's presentation, how we're going to work this first part of the presentation is that I, Audrey, will be going over all the coding changes, and then I'm going to pass it over to Cheryl who will discuss the quality impacts of these changes. Cheryl, what do you say about this MI?

Cheryl

I say a lot about this MI. This is actually probably one of the biggest changes, and I think it's a positive change. I do think it came from the cardiologist really asking CMS "You're killing us on our quality outcomes because typically this is not the main admission." Typically, the underlying cause of that MI, the sepsis and pneumonia, whatever it might be is where most of the treatment is focused." Many times, it's no need to be aggressively treated because it's non-cardiac in origin in that there are no coronary artery disease that's contributing to this patient having this type two or demand ischemia MI. As we all know, we have two conditions both present on admission, we were allowed to select either one from a coding perspective originally, before this guideline for this, and many times that MI was a really nice reimbursement and a lot of organization were sequencing the type two MI as principle.

I will also say on the flip side, I had some organizations that absolutely did not, gave their coders instruction not to sequence it as principle because they felt, again, that it wasn't the thrust of treatment. The good news is this clinically makes sense, and what that will do is impact our readmissions reduction program, that's less patients being readmitted in 30 days following a heart attack. When you think about a septic patient or a pneumonia patient or COPD patient, they are more likely to be readmitted due to those than poor management following an MI. I think that this is a very big impact. The other thing is the 30 day mortality following acute MI that's measured as part of the quality payment programs. This is also impacted positively because the cause of death typically in those patients who had the demand ischemic MI, it is not the MI, it's the underlying disease process. We get two upswings in terms of our performance metrics. Now, we might have a little bit loss of reimbursement, but in the long run I think that this is definitely positive impact on quality.

Audrey

Wonderful. The next topic that we're going to discuss is regarding pulmonary embolisms or PE. Two new codes were created under subcategory I26.9 pulmonary embolism without acute cor pulmonoale to identify single or multiple segmental pulmonary embolisms. These new codes are included in MS-DRGS 175 and 176 where the other PEs are classified. In addition, these two new codes are still considered MCCs.

Cheryl

The impact thereof is exactly what Audrey said. Since they're still MCCs by the way, they are on the HAC list for this year. What's unfortunate is these are not always clinically significant embolisms. They're usually an incidental finding, same way that our distal DVTs are an incidental finding. Stay tuned on the DVTs. That point is at this point, because CMS designate them as MCCs, they are in that HAC range and in the HAC list; however, I am hoping over time CMS will revisit these and maybe downgrade them. I don't know that they will or won't. The bad news is the new codes are HACs.

On the positive note, in the AHRQ methodology, they are all a version behind. They are currently on last year's code set, version 36. My thought, my opinion if that's what we'll use, is that when AHRQ goes to their next version, version 2020 as an example, I think that they will probably exclude those the same way they still cap and the superficial vein DVTs. Again, I believe that to be the case because CMS doesn't create a new code for no reason. They just don't say "Hey, here's a great new code that's usually at the heft of some organization." For example, these were created the hospitals for special surgery. You've got a surgical group saying I want to classify these separately in terms of risk adjustment. I anticipate AHRQ will fall in line, but I don't know that we're going to get any relief from the HACs unfortunately, and certainly not in the current year.

Audrey

Okay. Several new changes were made to the acute and chronic embolism and thrombosis codes in the lower extremities. First, inclusion notes were added for clarity. For the femoral vein, common and

Audrey continued

deep femoral vein were added as inclusion terms. For the iliac vein, the common iliac and internal iliac vein were added. Finally, anterior and posterior tibial vein were added to the tibial vein codes.

Next, new codes were added to delineate embolism and thrombosis of the peroneal vein. Notice that the codes include laterality, and these new codes are considered CCs. Finally, new codes were also created to classify embolism and thrombosis of a calf muscular vein. Notice that the gastrocnemial and soleal vein are included as calf muscular veins. Once again, these changes were made to both the acute and chronic embolism and thrombosis codes.

Cheryl

As we can imagine, lots of these new codes may or may not be impacting quality. Again, because that thrombosis, and I'm using the word DVT the same way that we say Kleenex sometimes, thrombosis is of course a clot in a blood vessel. DVT is of course referring to clots of the deep veins, but these calf veins are not deep veins.

Once you have moved beyond your popliteal, they start moving or grown out into the superficial area and they're considered superficial. Like I said, as you'll see we have two different types of calf veins. The three paired ones, the posterior tibial, peroneal, and anterior tib, and then the muscular veins, which are the soleal and gastrocnemial. Like I said, because those clots are in superficial, less significant veins, they tend not to need longterm treatment and they're usually, not always, clinically significant. Like I said, it's not a bad thing that they happen, they're less likely to break off, thrombose, travel up to the heart or lungs or brain.

Further on, taking us into a diagram. I think it's really helpful. I don't know if you are like me, when you're trying to visualize these blood vessels, I typically need to have a picture open to actually see those locators in terms of which is the soleus, and you can see again how small they are in diameter or how far out they are away from the deep veins. In terms of the impact on PSI 12, again AHRQ is on last year's version. These brand new codes will or will not be in AHRQs methodology until they upgrade.

On a positive note, they're already excluding those. That would have been assigned to unspecified code range. In other words, before we had the site specific ones, we had generic I82-44 and I82-49. The I82-44 is where the soleal, peroneal, gastrocnemius veins were assigned to. My assumption, and again I don't think I'm terribly wrong on this one, is that these would still be excluded once they upgrade to the new version. I think it will be important that we have these new codes because it's going to help us actually decide again, let's look at longterm studies. Which of these veins, are we correct in assuming these are significant. Is the peroneal, I call it peroneal, she calls it peroneal, is that a much more significant clot than a gastrocnemius. I think time will be able to tell by having code split. I think it will also allow a little bit more research. In immediate, not too much is changed with this because of HRQ using last year's version.

Audrey

Tomato, tomato. Now, let's discuss pressure ulcers. 25 new codes were created specifically identifying pressure-induced deep tissue damage, which is located in category L89 and designated with a final character of six. It may also be documented as deep tissue pressure injury or DTPI. Eight specific codes with laterality where appropriate are available. All of the new codes are classified to MDC 9.

In addition to the new codes, there were some index changes. Under the main term damage, deep tissue, pressure induced was added; however, you will notice that under the main term injury and sub-term deep tissue, meaning pressure ulcer, it still states "See ulcer, pressure, unstageable by site." During the coordination and maintenance committee meeting, which was held on September 10th, 2019, it was proposed to update the index from unstageable to category L89 with a final character of six. If this proposed change becomes finalized, it will be effective on October 1, 2020; however, to provide guidance on what to do in the meantime when deep tissue pressure injury is documented, fourth quarter 2019 Coding Clinic, pages 11 and 12, stated to assign only the appropriate code for pressure induced deep tissue damage L89 with the final character of six. It's quoted as stating "The new codes should be used instead of the unstageable codes."

Audrey continued

Corresponding changes to the guidelines were made to support the appropriate code assignment for pressure ulcer stages. The guideline now reads "Codes in category L89 Pressure Ulcer identify the site and stage of the pressure ulcer." In addition, deep tissue pressure injury was added to the severity list included in the pressure ulcer classification. In the unstageable pressure ulcer guideline, the statement regarding deep tissue injury being classified to the unstageable pressure ulcer codes was deleted. Finally, a new guideline was added simply stating "For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage L89 with a final character of six. Now Cheryl, that was quite a bit. Tell me a little bit about how this impacts on quality.

Cheryl

Certainly. First of all, this has been a long request from our National Wound Care professionals. They did not like that they were assigned to an unstageable wound. It is a different type of pressure injury, again I'm trying to not say decubitous, not trying to show my age. It's not the same, they don't have the same issues until the skin breaks open. They're clinically so different that they really wanted a unique code. This is, I think CMS needed to wait until we had gotten through enough years of I10 before they were going to put these new codes in, but I know the wound care nurses are rejoicing a bit here. Again, it's typically intact skin and for us it was boggy heels as our bedside nurses. It wasn't just a red heel, it would be mushy, that area where there's that pressure injury, or sometimes it'd be shown as a bruise or that deep red color.

How does this affect quality? Other than again it's not similar as there's not actually penetration of the skin and there's not eschar, let's talk about how it actually affects the quality implications. They are not on our HAC list. Of course, only stages three and four pressure ulcers have been HACs and these are not HACs either. Unstageable was not, but neither are these; however, there was a proposed change that I'm going to be talking about in a couple of slides where they might have downgraded all pressure ulcers, all the MCC ulcers to CCs and brought the non-pressure ulcer, the non three and fours, up to CCs. If they actually go through with that next year and subsequent years, in other words if all pressure ulcers suddenly become CCs, it's entirely possible that they will be included as HACs. I really don't know, but I can't imagine they would only make some of these HACs and some ulcers not HACs.

Second thing, as we've said numerous times, AHRQ is still on the old code set so these codes aren't recognized. Again, I really don't think that they will designate these as PSIs because it was for stage three, four, and unstageable. I think that they will just, again it's my guess that they will exclude those, that it's truly only going to be those that are unstageable in terms of they've got a big chunk of eschar and there's no ability to actually see how deep they go.

I think the biggest thing we can do in this interim, is we're really trying to see are we keeping these HACs, are we getting more HACs, less HACs, what is AHRQ doing, we need to make sure that our wound care staff know. Share with your friends, "Hey, the good news is we have a new code for that deep tissue injury or deep tissue pressure injury" making sure we're appropriately classifying them so if there are complications, we're not just saying unstageable because it really never mattered before if they called it unstageable versus DPI. We had one code. Now that we have separate codes, we need to be more precise than ever in our documentation.

Audrey

Now our next set of topics are related to the complication and comorbidity updates. Complications and comorbidities or CCs have been around since the implementation of DRGs in 1983. The last major overhaul of the CC list occurred in fiscal year 2008 when ICD 9 was still the classification system. At that time, CMS evaluated each diagnosis code to determine its impact on resource use and to determine the most appropriate classification non-CC, CC, or MCC, which stands for major complication and comorbidity. Since fiscal year 2008, CMS has evaluated individual diagnosis codes based on specific requests to change the severity level; however, CMS felt it was necessary to do a comprehensive review of the CC list again due to the significant change to the scope and specificity of diagnosis codes since the transition to ICD 10. CMS believed it would be prudent to further examine the severity designations to ensure that they would appropriately reflect resource use

Audrey
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based on review of the data as well as consideration as relevant clinical factors. CMS used the same methodology for this current comprehensive review as they did for the fiscal year 2008 analysis.

CMS originally proposed to change the severity level designation from 1492 diagnosis codes for fiscal year 2020. As you have all heard by now I am sure, CMS decided not to make a majority of the proposed changes to the CC and MCC list for fiscal year 2020; however, let's spend a few moments reviewing a few of the proposed changes that were not implemented as it may give us some insight into CMS action that CMS may take in subsequent years.

CMS proposed to change all 767 neoplasm codes currently designated as a CC to a non-CC. In addition, CMS proposed to change the severity level designation for 13 acute myocardial infarction codes from an MCC to a CC. CMS also proposed to change the severity level designation for 150 codes related to pressure ulcers. They proposed to revise the stage three and stage four pressure ulcers from an MCC to a CC and the stage one, stage two, and unstageable pressure ulcers from a non-CC to a CC. In other words, all your pressure ulcers would have been classified as a CC regardless of stage. If this proposed change was finalized, all pressure ulcers, regardless of stage would have been subject to the hospital acquired conditions or the HAC payment provision if the pressure ulcer was sequenced as a secondary diagnosis and not present on admission. CMS also proposed to change four codes related to anti-microbial drug resistance and one code related to homelessness from a non-CC to a CC.

Remember, all the information on this slide that I just discussed was proposed, not finalized. CMS decided it would be premature to adopt broad changes to the severity designations at this time. CMS agreed with the public comments that there have been significant changes to the scope and complexity of diagnosis codes since the transition to ICD-10-CM. CMS also believes at this time it would be prudent to further examine the proposed severity designations to ensure they would appropriate reflect resource use based on review of the data as well as consideration of relevant clinical factors to improve the overall accuracy of the IPPS payments. Postponing the adoption of comprehensive changes and severity level designations will allow CMS to incorporate review of additional ICD 10 claims data as it becomes available, and to fully consider the technical feedback provided from the public on the proposed rule. CMS will continue to evaluate suggestions from public comments and determine if they will make the comprehensive changes all at once or implement in phases.

I will let you know that that guideline for the public comments is November first. You've still got a couple more weeks to be able to get in any comments that you may have on this subject and see what they will do for next year. This is not going away. They are still planning on doing some changes to the CC and MCC list. Remember, all that I just discussed was proposed. What they did make finalized, or what they finalized, is the codes that you see on this screen. That is regarding the antimicrobial drug resistance codes. CMS changed the severity designation from non-CC to a CC for patients treated for an infection resistant to antibiotics. Resources required to treat patients suffering from antimicrobial resistant infections weren't a higher severity designation since these complications are more resource intensive. They require the need for stronger, different or extra antibiotics; therefore, CMS finalized the change to the severity level designation for all the codes in category Z16, not just those four that were proposed but all of the codes in category Z16.

Antibiotic resistance is a growing global crisis described by the World Health Organization as one of the biggest threats to global health, food security, and development today. According to the CDC, or the Centers for Disease Control and Prevention, more than two million hospital infections caused by bacteria resistant to greater than one antibiotic class occur every year in the United States, and over 23,000 patients with an antibiotic resistant pathogen die each year. The prevalence of multi-drug resistance or MDR pathogens is increasing. In particular, the CDC and the World Health Organization consider antibiotic resistance to be an urgent and critical threat to human health. I'll pass it back over to Cheryl to talk about some of the quality impacts.

Cheryl Thank you, Audrey. Well, obviously some of the quality impact is from a clinical standpoint, in other words having these new codes that alone allows us to study better and know where our resistance are increasing or decreasing. Some of this information of course is abstracted and sent to the Centers for Disease Control, that antibiotic resistance, but not all of that is. It depends on the type of infections that they're mandated to report on. Having these codes are really important; however, first of all, let's take it on the real level. We'll take off the clinical hat for a moment. We really need CDI and coding staff to know about these new codes, but it's not only knowing about them. Where would I look, how do you read that culture and sensitivity report? In other words, what does the S versus the I versus the R mean? What do those initial mean next to each one of those antibiotics when I have an infection. When they put it under a slide, they then test their resistance to the antibiotics.

Obviously, the second part of that is not just understanding there's a place to go look, we as doctors actually documenting this information in the medical record, we want to make sure that the coders capture all this. Because they're Z codes, some organizations may have some always code or don't worry about coding certain types of things in the Z code range. This is one that we want to put on our really always code list when it is documented. The other part of that is not only educating CDI and coding, it's educating our providers. I need you to pull that information in. It may seem counterintuitive to have to document it, you can go look at the culture and sensitivity, Cheryl. You can see right there that there's an I or an S or an R there. You should be able to read that. That's counterintuitive to physicians, but we're asking them for good transition of care. It's not just about how we can code it, but it's also good transition of care for the patient.

In a side note, just to remind you, that history of infection codes in the Z86-1 range or Z87.440, these are also utilized for risk adjustment for all cause readmissions. While you're making sure you're getting the antibiotic resistance captured, don't forget those history of infections, making sure we're capturing those. Again, it may not seem important to today's visit, but because they've been infected before that puts them at a higher risk of coming in with new infections or having complications.

In terms of the other CC and MCC changes not finalized that may be in the future, obviously if those HACs were lower, less frequently done, obviously we're going to have less MCCs because they're downgrading from any of those fractures. The hospitals are actually going to, it's not that we'll have less HACs, the HACs will be lower reimbursed shall we say. We'll lose less money from a HAC. With pyelonephritis, that was also on the list of being downgraded. Again, that would not have been on that CC additional diagnosis list in the combination with CAUTI. The same thing with the HACs. I think it's a trade off. You would have less MCC losses for HACs, for pressure ulcers three and four, but potentially again that would be offset by the increase in the CC HACs for the all stage ulcers. I don't know that it's a win-loss.

As Audrey said, I don't think that we are off the hook. I think we have a temporary reprieve. I think we have a stay of execution on all the MCC changes, and I would anticipate probably within the next three years, again I think Audrey, you probably agree that it's probably going to happen within another couple of years once truly they have done some more longitudinal studies on cost, et cetera.

Audrey That, and we'll have to see if they're going to do it all at once or take it over a series of years actually.

Cheryl I think we'd all hope for that one. Ease our pain a little bit. With that, Jared would you go ahead and launch our next polling question please?

Jared Yes. Okay. It is live.

Cheryl Great. As you're answering this polling question, it's a nice easy one, we're going to transition away from those code updates and coding guideline updates that Audrey has given us, and we're going to pivot into the rest of the IPPS rule. Not only did they give us new codes, deleted codes, and coding guideline changes, they also gave us changes to the quality reporting program. That's where we're going to move forward. If you would give us our poll results, please.

Jared Okay. We had 28% said always, 31% said often, 27% said sometimes, nine percent said rarely, five percent said never.

Cheryl Right. It's not enough that your organization study the code changes to see how they impact, are they actually disseminating it out. Then you think of some of the changes this year, you can hear how I said let wound care know, let providers know, teach our coders how to interpret a sensitivity report for appropriate queries. We have to disseminate that information and not just hold it tight and say "Eh, doesn't look like that big of a year." Again, I think you need to have that communication plan for your new changes.

Okay. Let's talk about those CMS changes for quality. As a reminder, as the slides move so slowly, we have four Medicare quality programs. We have the inpatient quality reporting program, IQR. Again, I apologize the slide jumped forward on us. We also then have the HAC reduction program, hospital value-based purchasing, and a hospital readmissions reduction program. CMS every year in their proposed and final rules comments on any changes to these programs because, again, these are legislative programs. In other words, without a change in the law, these programs will still have to be in place. They also have to report how and what they're changing.

The first change is to the hospital-wide all cause readmission or HWR program also described as all-cause readmissions. There are two voluntary reporting periods. There was a test group that was actually sending in data for the last couple of years for CMS to test the model. They're extending that testing period or that voluntary reporting period from July 1, 2021 through June or 2022 and then July 2022 to June 2023. Following that, it will move from voluntary to required reporting starting, again, July 1, 2023. That would potentially impact hospitals reimbursement for fiscal year 2026 onward. At the same time as they're creating this new hospital-wide readmissions measure, this hybrid measure, they're going to remove our existing hospital-wide readmissions measure that same year, but the hospital readmissions reduction program, HARP, is not changing. There are no changes in it this year. This is more about our hospital-wide readmissions.

The other thing, just to make sure that you all know is that for those that are voluntarily reporting, CMS is not going to publish their scores because they're not part of that all-cause readmission. Those hospitals won't be describing that. What does this measure look like? It's really the same as the existing all-cause readmission. It's measuring unplanned readmission within 30 days, and they go on to state all unplanned readmissions are considered an outcome regardless of the cause. They're still five mutually exclusive cohorts that you see listed here and excludes patients that are admitted to NPPS except cancer hospital without 30 days of enrollment in Medicare, if the patient is discharged AMA or if admitted for primary psychiatric conditions, rehab, or medical treatment of cancer. In terms of risk adjustment, what makes that more likely they'll be readmitted, they're using the same method as the existing all-cause program including the hospitals case mix and service mix, patient's age and comorbidities.

What's different is what you're seeing at the bottom. Hospitals are now also having to report vital signs and lab results for 90% of the discharge patients in something called linking variables on 100% of their linking variables, which includes these items you see listed below. This is the new part of the measure. It's everything in the old measure plus one. What are the vital signs and lab results that they're looking for? It's looking for a combination of administrative claims. Sorry, again the slide is being a little jumpy today. Apologies. It's using a combination again that administrative data and something they describe as core clinical data including the heart rate, temperature, systolic blood pressure, respiratory rate, oxygen stats, patient's weight, their white count, their hematocrit, potassium, creatinine, bicarbonate, and glucose. The reason that they're using this set of information is people who have had concerns and frustrations with the readmission say you need to factor in more clinical information about my patient, why it makes them more likely to be readmitted.

Cheryl
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What this is requiring though is that this is an EHR extracted measure. In other words, your hospital's EHR has to build a program to pull the information out and get it ready to be submitted as part of the IQR program. It's a little bit more convoluted, which set of vitals, how often, what are they using, which labs? There's a lot more detail for those that are interested, but it's actually trying to account for those variations, not just in my patient chronic conditions, but their acute current state that would risk adjust them.

Our next impact that we're going to discuss is the hospital's readmission reduction program. As I said, they really didn't change it, but I do want to talk to you a little bit about that. There was a leading, the MedPAC. MedPAC is the advisory, they're a legislative advisory board to Congress on Medicare matters. As part of their MedPAC meetings, they presented an evaluation of the program at their September 2019 meeting. What they did is they provided Congress updated 2016 and '17 readmissions data, and they also refuted a recent study that had been published that was associating declining readmission rates, which is a positive, with higher discharge mortality. They said that when they did their analysis, they did not see that there was a correlation between less readmissions and mortality. What they did say to Congress is that obviously, as we know, risk adjusted readmissions are continuing to decline. The declining rates I can't see a correlation in increased risk, and that the program is meeting its objectives. Its objectives are to reduce readmissions.

Interestingly enough, and why I wanted to share this with you today, they also made a recommendation, which they also did at their January meeting with Congress, that they felt that they are recommending we combine the hospital readmissions reduction program, the HAC reduction, and the value-based purchased program into one program called HVIP, Hospital Value Incentive Program, and to completely remove the Hospital Inpatient Quality Reporting Program. Obviously, at this point CMS has not adopted this proposal. It's not in the final rule, they've suggested it twice, CMS has not acted on it. I just find that interesting because there was a lot of studying in the last couple years about the three quality payment programs here and whether or not they were duplicate or necessary. CMS analyzed them and said all three are distinct separate with intents and objectives, so MedPAC is still questioning that. I think time will tell. I really can't imagine that they're going to totally eliminate the IQR program though because that does seem a little bit overkill.

Our next impact that we're going to study is to the AHRQ. It's not, of course, part of the final rule, but we know that AHRQ is mandated by CMS so want to throw into you what it was changing with our version, 2019 that was released July 31st of this year. It came from many conventions from versions into years, which I think is lovely. The code set version 2019 is affected with a discharges from October 2018. They always do that because they release that change in the middle of a version so they always have to go back to the previous version. They also updated the new codes and DRGs from version 36, not all brand new codes and DRGs that we just released. They're always a version behind. What was also of course exciting is they finally provided us benchmarks and thresholds for performance in terms of what should be our expected rates of PSI, and remember this is for all payer.

As a side note, CMS does not use AHRQ methodology as part of the HAC reduction program. They are using their own recalibrated version 9.0 and you can see the reference population that they're using as their baseline, and then their performance period. CMS is looking at just the Medicare patients and saying where the expected rates. Medicare uses the methodology in terms of what is a PSI, but they set their expected rates and thresholds based, again, on a subset of patients. Otherwise, in version 2019, they modified PSI 02, Death Rate and low-mortality DRG groups. They added hypertension as a low-expected death and femur fracture, which I thought very interesting.

Finally, just 812 anemia that did not include 811 anemia with MCC because the expected death rate will be greater than 0.5%. They also removed DRG 202, bronchitis and asthma with CC or MCC as one of the DRGs that would flag a PSI 02. Again, it's probably because again it exceeded the threshold. Finally, they retired PSI 16, transfusion reaction count, which is certainly important and necessary because it was a very low numerator on a good day and one transfusion reaction would really sway your data. It really did not become a good measurement of what they were intending to do. It had aged itself out.

Cheryl
continued

Okay. Sorry. Love with the slides. Next, we're going to talk about electronic clinical quality measures or eCQMs. We used to call these core measures. On of the new ones is involving opioids and benzodiazepine substance related overdose. Of course, you can see that the fatalities have really become an epidemic. I think we all know this, but they basically said more than 42,000 deaths a year were due to opioid overdose and 40% were due to prescription opioids, which is even more disturbing. They did a retrospective study of claims that said our use of concurrently using both a benzodiazepine and an opioid together has increased by 80% between 2001 and 2013. Of course, that really contributes to the risk of overdose. Of course, clinically speaking you know that using both medications together increased the risk of respiratory depression, and like I said the scariest part for me was the concurrent use of both was present in more than 30% of fatal overdoses.

CMS has got to deal with our opioid crisis and by that they're not adding a measure to our IQR program. What they're measuring is how often we are actually [inaudible 00:45:44] prescribing at discharge both a benzodiazepine and an opioid. There was a lot of question and commentary as they were creating this new IQR. Should we be doing both? Again, I apologize as the slide does not want to go forward today. I'm having one of those technical days. There it goes. They also noted, again, the rates of fatal overdose was 10 times higher who were co-dispensed and, sorry again the slide deck has really jumped forward. I apologize. It is being very sensitive to my keyboard today. This eQRM is looking at the rate of again concomitant prescription at discharge of both an opioid and a benzodiazepine regardless of the patient being on there prior to admission. In other words, it doesn't matter.

Then looking at two more, opioids or opioids in combination with benzodiazepines. There are no exclusions for patient populations, and like I said, we are the stewards of our patients at discharge. We should be trying to taper them down, reduce them. They also said we're not expecting a zero rate of prescriptions because obviously some patients are going to need that information but they will exclude patients with active cancer or palliative care status at time of discharge because of course, clinically there is no benefit in reducing opioid use in those populations. Like I said, they're not expecting the zero rate. In addition to this confirmed new eCQM which we'll start reporting in calendar year, there's a difference of calendar year instead of fiscal year, there are some proposed ones.

The first one is again, you'll see here in a second, was regarding hypoglycemic events. It's another thing that they're concerned about is that we are not adjusting their anti-glycemic agents while in a hospitalization. Really was [inaudible 00:48:13] when measured under the NSQIP program, and it is monitored by AHRQ. This would be again, a direct extraction from the EHR so it's not based on codes, it's based on the documentation. It's looking at how many of those had a severe hypoglycemic event within 24 hours of being given an antihyperglycemic medication. This had already gone through our National Quality Form approval; however, that was in its chart-based measure, not electronic submission forms. They are working on it, continuing to move this forward. In other words, it's not effective yet this year, but I would say within the next two years this will have moved forward through the approval process and be part of the IQR program, so stay tuned.

In addition to the severe hypoglycemic, there was another one that really was interesting to me and that is pressure ulcers. We know that we have been measuring and there's HACs and there's PSIs and then potential preventable complications or PPCs in the 3M methodology. Weirdly enough that they're adding them to the inpatient quality program. Again, it's not confirmed yet, they're moving through it. Again, it'll be a direct extraction instead of claims data, and they would be including stage two as well. You'll notice the parameter wasn't present within the first 24 hours. Again, this has been moving through an NQF approval process, it just has not made it all the way there. They're not, it doesn't look like they're even excluding one because like I said clinically those patients with low albumins, et cetera, those are ones I should have protected more. I shouldn't get a pass for failing to protect our most vulnerable patients. Again, I think in the next couple of years we will see this moving through the system.

Cheryl continued

The IQR program in addition to, like I said the new eCQM, and then those two proposals, there were a couple of others that were really interesting that I would point you to. Our last change is some of the other required measures that hospitals have to report on. That's where we'll end up finalizing today.

The first one, and I think happy flu season as we start, is the influenza vaccination coverage among hospital personnel. Hospitals will have to report what percentage of their employees are vaccinated. Interestingly enough, complications following hip and knee surgery. We're already measuring this for the hospital value-based program in the safety domain, like the pressure ulcers, interesting they're duplicating. The patients over paperwork initiative of 2017 was trying to remove duplication, and then now added two duplications. In addition to these two new measures that will be required as part of the IQR program, they're adding 30 day mortality found acute ischemic stroke. In addition to the AMI, pneumonia, and CHF, they're adding stroke moralities. You can see the years. Finally, they're also reporting as part of IQR program are PSI 04 death rate, again a duplication. Then the last new part of the IQR program is excess stays in acute care after hospitalization for AMI, heart failure, and pneumonia. Again, it's a brand new measure, and it'll be interesting to see what they're tracking and why they're doing it. They've not given us a lot of detail. They just noted this was a new part of the program.

Not big crazy changes, just a lot of subtle things coming, and especially in the eCQM world. With that, we'll turn it back to Jared.

Jared Yeah. Let's go to the next slide.

Cheryl Absolutely.

Jared Yeah. Audrey, do you want to talk a little bit about this?

Audrey Yeah. We are putting on an on-demand educational video regarding all of the fiscal year 2020 IPPS changes. It will be discussing in detail and giving some behind the scenes and some background information on the coding updates for diagnosis and procedures as well as the official coding guidelines, what changed from MS-DRG and an APR-DRG effective October 1st. Also, we're going to get some more information on the financial impact of how even discussing a little bit more about the CC and MCCs that were proposed but not finalized, what they could have done to you, and how can you prepare for that for the future? It's really getting into a lot of information. If you would like some more information on that, you can send us an email or actually go to the website and get some additional details at 3M.com/IPPS.

Jared Awesome. Thank you so much. If we go to the next slide, we have a poll. If you are interested, like Audrey was saying, if you select yes here, we will send you some more information via email or you can go directly to that website that we had listed there. I'm going to launch that. Okay. While that's filling out, let's move into the Q&A portion of the webinar. If you'd like to submit a question, you can use the questions feature in your web meeting controls located in the lower right corner of your screen. We'll start with the first question, are hospitals not penalized for poor performance via the IQR program?

Cheryl Great question. The IQR program is mandatory for the IPPS payment paid hospitals. In other words a required program. It is a process based measure, in other words they're measuring how often we do things. It's not outcome, it's in other words how did our patients look or what happened to our patients as a result of this. The IQR program is not voluntary, so if you fail to submit the appropriate data elements and required data elements, the hospital will receive a decreased reimbursement but not in the same way that they would via value-based purchasing or HAC reduction program. In other words, if you don't submit data, you're penalized. If you do submit data, regardless of your performance or the low process that you're doing, you will not be penalized.

Jared Great. Okay. Next question, how are the resistance codes to be documented? Does it have to be documented by the provider?

Audrey Yes. I'll take that one. All of your diagnosis codes, most of them, there are a few exceptions, need to be documented by the physician. This is one that is not an exception. You need to, the physician will need to document some information. Sometimes, there's some lab information that talks about that it's resistant, but we cannot from an inpatient setting code from lab values. We do need to get that information documented by the physician into the body of the record, progress notes, discharge summary, somewhere like that so that we can be able to pick up that information.

Jared Okay. Great. Next question. Would you know if the ICD codes are identified in the professional discharge note? Does that satisfy HCC requirements rather than asking the provider to address the ICDs at each daily rounding visit?

Audrey Cheryl, I'm not sure I totally understood that question.

Cheryl I think the question is for those chronic HCCs, in other words those more chronic conditions that qualify as HCCs, I think the question is is it sufficient enough that the physician is addressing the HCC management in the discharge summary only or should it be throughout the body of an inpatient's stay. I think my statement would be, and I think you'd agree, that if a diagnosis needs reporting as it's evaluated, monitored, treated, extending length of stay, or increases care of resources that's captured regardless of where it's documented in the record. With that list of HCCs in my discharge summary, I would expect them to be addressing the ongoing management in some form or transition to outpatient. Audrey, any other thoughts than that?

Audrey No. Just to reiterate what you said, once again, with the coding of any secondary diagnosis, it has to be documented by the physician. It can be anywhere that's a part of or what is considered a part of the inpatient medical record. It has to be, it could be in a provider note, but if that provider note has to be a part of the medical record so progress notes, consult, H&P, discharge summary. Then we do have to make sure it's clinically significant. What did they do for the condition, how was it a factor for this current encounter so that we can pick it up. That is basically measured by was it evaluated, monitored, treated, increased nursing care, increased length of stay. Yes, Cheryl, you did say that. It's just one of those things that you just have to reiterate.

Any secondary diagnosis needs to have, even a chronic condition, needs to meet two requirements. One that it's physician documented, and two evaluated, monitored, treated, increased nursing care, increased length of stay. That's what makes it reportable.

Jared Great.

Cheryl Again, for some of those... Sorry. For some of those chronic conditions I just want to tag the second part of it is it may not have bearing now, but as they're transitioning the patient to outpatient they might be readdressing these chronic conditions that they want to make sure that outpatient physician is now going to take care of. In other words, it's not only what we did on this day, how are we passing the baton to the outpatient physician on those conditions. That would also be appropriate.

Jared Great. Okay. I think that's all the time we have today. If we didn't get to your question, we'll make sure to follow up with you via email. Just a reminder that we will be sending out a link to the archive, so look for that in your inbox in the next week, and that will also include the slides. Also, when you exit the webinar today, watch for a short survey after we finish here with the Q&A. We would like your input as we refine plans for the 2020 quality webinar series. Let us know what you'd like to see covered next year.

Cheryl and Audrey, thank you for this excellent presentation, and thank you all of you for joining us. This concludes today's 3M Health Information Systems webinar.