



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 16: Inpatient Payment and Patient Responsibility

I. Part A Payment for Hospital Inpatient Services

The Inpatient Prospective Payment System (IPPS) applies to most acute care hospitals, except:

- Psychiatric hospitals – Inpatient Psychiatric Facility (IPF) PPS
- Rehabilitation hospitals – Inpatient Rehab Facility (IRF) PPS
- Long-term care hospitals – Long Term Care Hospital (LTCH) PPS
- Designated children’s hospitals and cancer hospitals – paid at cost
- Critical Access Hospitals (CAHs) – paid at cost
- Hospitals in US territories – paid at cost
- Maryland hospitals under the Health Services Cost Review Commission (HSCRC) – paid under a Total Cost of Care demonstration through 2026

A. Overview of Inpatient Prospective Payment System (IPPS)

1. The IPPS pays hospitals a prospectively determined fixed payment amount for each discharge covered by Medicare, regardless of the costs incurred by the hospital to treat the patient. <42 C.F.R. 412.1>
 - a. The IPPS payment constitutes payment in full for all covered services provided directly or under arrangement by the admitting hospital and furnished in connection with the admission. <42 CFR § 412.2(b)>
 - i. If the admitting hospital cannot provide needed therapeutic or diagnostic services, they must provide the services “under arrangement” with another provider either in the hospital or at a location outside the hospital. <42 CFR § 412.50(c), 76 Fed. Reg. 51714>
 - ii. “Routine services” (e.g., bed, board, nursing services, use of hospital facilities and medical social services) must be provided by the admitting hospital. Services are considered to be provided by the admitting hospital if:

- a) They are provided in the hospital; and
- b) The hospital exercises professional responsibility over the services, including quality control. <76 Fed. Reg. 51711-51714; 77 Fed. Reg. 53453>

Case Study 1

Facts: A patient is transported (but not discharged) from the St. Charles hospital to a medical center hospital in downtown St. Louis to have a PET scan performed (assume that the PET scan was medically necessary and that all of the Medicare conditions of coverage applicable to the PET scan were met). The PET scan was performed on an outpatient basis and the patient was returned to the St. Charles hospital. Which hospital should bill Medicare for the PET scan?

- B. CMS publishes an annual IPPS update (including changes to the payment rates) in the Federal Register around August 1 each year.
 - 1. The update becomes effective on October 1 of each year – the first day of the federal government’s fiscal year.
 - 2. CMS maintains a final rule home page for each year on their website containing many documents including payment tables (e.g., wage index, standardized amounts) and other tables (e.g., CCs and MCCs) that will assist hospitals in preparing for changes each year.

Link: FY2024 IPPS Final Rule Home Page under Medicare-Related Sites – Hospital

II. Medicare Severity Diagnosis Related Groups (MS-DRGs)

- A. Payment under IPPS is made using “Medicare Severity Diagnosis Related Groups” (“MS-DRGs”).
- B. The list of MS-DRGs is published as Table 5 to the annual IPPS final rule, included in the Supplement to these materials. There is a total of 766 valid MS-DRGs for FY 2024.
 - 1. The MS-DRGs number to 999, with gaps in the numbering for future inclusion of additional MS-DRGs near similar conditions.
 - 2. The individual MS-DRGs are generally further grouped into one of 25 “major diagnostic categories” or “MDCs” or categorized as “pre-MDC” to assist in the final assignment of the MS-DRG.

- a. The MDCs are generally based on the organ/body system affected (e.g., MDC 9 - diseases and disorders of the skin, subcutaneous tissue and breast) or the nature of the disease or injury (e.g., MDC 22 - burns).
- 3. Every discharge is assigned only one MS-DRG in a process called “grouping”, discussed below. <42 CFR § 412.60(c)(2)>
- 4. Each MS-DRG is assigned a relative weight reflecting the “estimated relative cost of hospital resources” required to care for a patient assigned to the particular MS-DRG. <42 CFR § 412.60(b)>

C. MS-DRG Assignment

1. The GROUPER

- a. The MACs (and most hospitals) use a software program called a GROUPER to determine MS-DRG assignment.
- b. CMS publishes the MS-DRG Definitions Manual and Software on their website.

Link: MS-DRG Classifications and Medicare Code Editor (MCE)
Definitions under Medicare-Related Sites – Hospital

2. Five Factors Driving MS-DRG Assignment

- a. Each discharge is assigned a MS-DRG based on:
 - i. Principal diagnosis (reported using an ICD-10-CM diagnosis code)
 - a) The “principal diagnosis” is “the diagnosis established after study to be chiefly responsible for causing the patient’s admission to the hospital.” <42 CFR § 412.60(c)(1)>
 - ii. Complications and comorbidities (reported using ICD-10-CM diagnosis codes)
 - a) Some discharges with the same principal diagnosis or procedure are subdivided into different MS-DRGs based on the presence of additional secondary diagnoses known as complications or comorbidities (“CCs”) or major CCs (“MCCs”). The CCs and MCCs are listed in Tables 6J and 6I, respectively, of the IPPS Final Rule each year.

A base MS-DRG may be sub-divided in one of three ways to recognize the patient's severity of illness:

- The MS-DRG with MCC, with CC, or without CC or MCC
- The MS-DRG with, or without CC/MCC
- The MS-DRG with, or without MCC

- 1) Some CCs or MCCs do not affect MS-DRG assignment when reported with certain specific principal diagnoses because they are closely related. The secondary diagnoses excluded from being treated as a CC or MCC for a particular principal diagnosis are listed in Table 6K of the IPPS Final Rule each year.
- b) Handout 24 contains a Group Exercise illustrating the impact of CCs and MCCs on payment.
- c) Hospital Acquired Conditions (HACs)
 - 1) The Deficit Reduction Act of 2005 required that specified conditions will not be considered CCs or MCCs when acquired at the hospital. <79 Fed. Reg. 49876-880>
 - (a) CMS sometimes refers to these conditions as “DRA HACs” to distinguish them from other hospital acquired conditions used in other quality payment adjustments.
 - (b) The current list of 14 DRA HAC categories is included in the materials behind the outline. <80 Fed. Reg. 49351>
 - (i) The list of diagnosis codes included in each category is updated annually and can be obtained on the Hospital Acquired Conditions page on the CMS website using the “ICD-10 HAC List” link on the left navigation.

Link: Hospital Acquired Conditions (Present on Admission Indicator) under Medicare-Related Sites – Hospital

- 2) A condition is considered hospital acquired if it has a POA indicator of:
 - (a) “N” - Diagnosis was not present at time of inpatient admission, or

(b) “U” - Documentation insufficient to determine if the condition was present at the time of inpatient admission. <79 Fed. Reg. 49878>

3) Costs associated with HACs are considered covered inpatient costs and should be billed on the associated inpatient claim. <See 72 Fed. Reg. 47201>

(a) Costs associated with HACs may contribute to cost outlier payment for the particular case. <See 72 Fed. Reg. 47201>

Case Study 2

Facts: A 66 year old male Medicare beneficiary was discharged from a St. Charles, Missouri hospital with a principal diagnosis of simple pneumonia. Simple pneumonia maps to MS-DRGs 193-195 depending on the additional diagnoses of the patient. The only other diagnosis the patient had was a stage III decubitus ulcer (an MCC) and the documentation was insufficient for the coder to determine if the ulcer was present on admission, however it was noted in the nurses’ admission notes and the physician’s discharge summary. What MS-DRG does this case group to?

Modified Facts: Would it be appropriate for a coder at the St. Charles hospital to query the physician as to whether the decubitus ulcer was present at the time of admission?

iii. Procedures performed (reported using ICD-10-PCS procedure codes)

a) MS-DRGs that involve surgical procedures are often referred to as “surgical MS-DRGs.” MS-DRGs that do not involve surgical procedures are often referred to as “medical MS-DRGs.”

iv. Gender and discharge status

a) In some cases, MS-DRG assignment is affected by the patient’s gender (e.g., MS-DRG 707) and/or discharge status (e.g., MS-DRG 280-285).

v. Transplant, ECMO or Tracheostomy cases

a) Certain transplant, ECMO and Tracheostomy cases are assigned directly to one of the “Pre-MDC” MS-DRGs.

III. Patient Responsibility (i.e., Deductibles and Coinsurance)

A. Benefit Periods

1. The inpatient deductible and coinsurance are based on a “benefit period” concept.
 - a. The benefit period begins to run when the patient is first admitted to a hospital or SNF for inpatient care. The benefit period ends when the patient has not been an inpatient of a hospital or SNF for 60 consecutive days. <42 CFR §§ 409.60(a), 409.60(b)>

A benefit period can be as short as 61 days and there can be multiple benefit periods in a calendar year, resulting in payment of the deductible multiples times in a single calendar year.

- i. SNF admissions and discharges affect the benefit period determination regardless of whether the beneficiary’s SNF care qualified for Medicare coverage. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 § 10.4.3.2 (Example 3)>

B. Deductible and Coinsurance Amounts

1. The first 60 inpatient hospitalization days of a benefit period are considered full benefit days and the patient is only responsible for paying the inpatient deductible. <42 CFR § 409.61(a)(1)(i)>
 - a. For 2024, the inpatient deductible is \$1632 per benefit period. <88 Fed. Reg. 71553>
 - b. The deductible is based on the calendar year in which the benefit period began. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.3>
2. Inpatient hospitalization days 61 to 90 in a benefit period are considered coinsurance days and the patient pays a daily coinsurance. <42 CFR § 409.61(a)(1)(ii)>
 - a. For 2024, the daily coinsurance is \$408 (25% X \$1632) per day. <88 Fed. Reg. 71553>

Case Study 3

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2023.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

3. Lifetime reserve days <42 CFR §409.61(a)(2)>

- a. Medicare beneficiaries have 60 “lifetime reserve days” that may be used after the full benefit and coinsurance days for a particular benefit period have been used.

Full benefit and coinsurance days are renewed each benefit period, but once the 60 lifetime reserve days are used, they are exhausted forever.

- b. For each lifetime reserve day, the patient is responsible for a daily coinsurance. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 §§ 10.2.1, 10.3>
 - i. For 2024, the lifetime reserve day coinsurance is \$816 (50% X \$1632) per day. <88 Fed. Reg. 71553>
- c. Use of Lifetime Reserve Days for Admissions with Exhaustion of Regular Benefits
 - i. If the beneficiary has at least one regular benefit day at the beginning of the stay and exhausts their benefits *during* the stay, the beneficiary will be deemed not to use their lifetime reserve days for the *non-outlier* portion of the stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1 (2)>

- ii. If the admission reaches outlier status, the beneficiary may elect not to use their lifetime reserve days for the days after the outlier is reached. If the beneficiary elects not to use their lifetime reserve days, Medicare will not make an outlier payment to the hospital and the hospital may charge the beneficiary for the charges that would have been paid as outlier by Medicare. <Medicare Benefit Policy Manual, Chapter 5 § 30.4.2>
- d. Election Not to Use Lifetime Reserve Days
 - i. Hospitals are required to notify beneficiaries that they may elect not to use their lifetime reserve days for all or part of a stay. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - a) Ideally, the notice should be given when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period. <Medicare Benefit Policy Manual, Chapter 5 § 30.1, MLN Matters Article SE0663>
 - b) CMS provides model language for use by beneficiaries in making an election not to use lifetime reserve days. <Medicare Benefit Policy Manual, Chapter 5 § 40.1, MLN Matters Article SE0663>
 - c) A retroactive election not to use lifetime reserve days may be made if certain criteria are met. <Medicare Benefit Policy Manual, Chapter 5 § 30.3, MLN Matters Article SE0663>
 - ii. If the beneficiary elects not to use lifetime reserve days, then the hospital may bill the patient for any services provided after the beneficiary's full benefit days and coinsurance days are exhausted. <42 CFR §409.65(a)(4)>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient is transported (but not discharged) from the St. Charles hospital to a medical center hospital in downtown St. Louis to have a PET scan performed (assume that the PET scan was medically necessary and that all of the Medicare conditions of coverage applicable to the PET scan were met). The PET scan was performed on an outpatient basis and the patient was returned to the St. Charles hospital. Which hospital should bill Medicare for the PET scan?

Analysis: The St. Charles hospital would include the PET scan on its inpatient claim. The PET scan would be considered to have been provided “under arrangements.” It would not be appropriate for the St. Louis hospital to bill Medicare directly for the PET scan. <42 C.F.R. 412.50(c)>

Case Study 2

Facts: A 66 year old male Medicare beneficiary was discharged from a St. Charles, Missouri hospital with a principal diagnosis of simple pneumonia. Simple pneumonia maps to MS-DRGs 193-195 depending on the additional diagnoses of the patient. The only other diagnosis the patient had was a stage III decubitus ulcer (an MCC) and the documentation was insufficient for the coder to determine if the ulcer was present on admission, however it was noted in the nurses' admission notes and the physician's discharge summary. What MS-DRG does this case group to?

Analysis: MS-DRG 195 Simple Pneumonia and Pleurisy w/o CC/MCC. The decubitus ulcer would be coded with a POA indicator of "U" because the documentation is insufficient to determine if it was present at the time of admission. A stage III decubitus ulcer is a HAC that is excluded from grouping when reported with a POA indicator of "U".

Modified Facts: Would it be appropriate for a coder at the St. Charles hospital to query the physician as to whether the decubitus ulcer was present at the time of admission?

Analysis: Yes, queries in this situation are specifically approved by the official POA coding guidelines. <Official ICD-9-CM Guidelines, Appendix I "POA Examples">

Modified Facts: In response to the query, the physician documented that the decubitus was indeed present when the patient was admitted. What is the MS-DRG assignment for the case now?

Analysis: MS-DRG 193 Simple Pneumonia and Pleurisy w/ MCC.

Case Study 3

Facts: A Medicare beneficiary who had never before been hospitalized was admitted to and stayed in a hospital for 58 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility for 14 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to a hospital for a four-day stay and then discharged to home. All services were provided during 2023.

What is the patient's hospital deductible and/or coinsurance liability for Admission #1? For Admission #2?

Analysis: For Admission #1, the patient would pay the deductible of \$1,600 on day one of the stay and it covers all 58 days of the admission. For Admission #2, the patient would pay \$400 for day three and four, for a total of \$800. Note that day one and two of Admission #2 are paid for with the deductible paid during Admission #1. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.1 and 10.3>

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 5 days. What is the beneficiary's total deductible and coinsurance liability for Admission #3?

Analysis: For Admission #3, the patient would pay the deductible of \$1,600. The patient began a new benefit period with the 60-day break between Admission # 2 and #3. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.1 and 10.3>

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List of Hospital Acquired Conditions Deficit Reduction Act of 2005

Excerpted from the CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions



Hospital-Acquired Conditions

Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary to identify conditions that are: (a) 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) could reasonably have been prevented through the application of evidence-based guidelines.

On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, CMS included 10 categories of conditions that were selected for the HAC payment provision. Payment implications began October 1, 2008, for these Hospital Acquired Conditions. The IPPS FY 2009 Final Rule is available in the **Statute/Regulations/Program Instructions** section, accessible through the navigation menu at left.

These 14 categories of HACs listed below include the HACs from the IPPS FY 2013 Final Rule which are Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization. For FY 2014 through FY 2023, there are no additional HAC categories added:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burn
 - Other Injuries
- Manifestations of Poor Glycemic Control

- Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
 - Total Knee Replacement
 - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

The ICD-10 HAC Lists for FY 2016 through the current FY year are available in the ICD-10 HAC List section, accessible through the navigation menu at left.

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application of this methodology. In the FY 2007 IPPS final rule, we discussed our rationale for implementing cost-based weights over a 3-year transition period. We stated that the 3-year transition would mitigate the annual payment effects from the changes to the relative weights while we further study whether to make adjustments to account for charge compression. We believe that the cost-based methodology reduces bias in the relative weights and makes Medicare's payments more accurate for both medical and surgical DRGs. Therefore, any delays in the transition would not further our goal of payment accuracy. We believe that current efforts to improve cost reporting and our decision not to implement regression-based CCRs will alleviate concerns about additional fluctuations in hospital payments from further changes to the relative weight methodology. Furthermore, we believe that, for some types of hospitals (such as rural hospitals), the payment changes from MS-DRGs are the opposite of those that will occur from the transition to cost-based weights. For this reason, we believe a 2-year transition of the MS-DRG system that coincides with the remaining two years of the transition to cost-based weights will reduce the magnitude of annual payment changes and achieve our long-term goal of improvements in payment accuracy. Therefore, we are continuing with the 3-year transition to cost-based weights. For FY 2008, the DRG relative weights will be a blend of 33 percent of charge-based weights and 67 percent of cost-based weights. For the first year of the MS-DRG transition, the relative weights will be a blend of 50 percent of the CMS-DRG weight and 50 percent of the MS-DRG weight.

F. Hospital-Acquired Conditions, Including Infections

1. General

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length. In many cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for other cases in the same DRG. To this extent, the IPPS does encourage hospitals to manage their patients well and to avoid complications, when possible. However, complications, such as infections, acquired in the hospital can lead to higher Medicare payments in two ways. First, the treatment of complications can increase the cost of hospital stays enough to generate outlier payments. However, the outlier

payment methodology requires that hospitals experience large losses on outlier cases (for example, in FY 2007, the fixed-loss amount was \$24,485 before a case qualified for outlier payments, and the hospital then only received 80 percent of its estimated costs above the fixed-loss cost threshold). Second, under the MS-DRGs we are adopting in this final rule with comment period, there are 258 sets of DRGs that are split into 2 or 3 subgroups based on the presence or absence of a major CC (MCC) or CC. If a condition acquired during the beneficiary's hospital stay is one of the conditions on the MCC or CC list, the result may be a higher payment to the hospital under the MS-DRGs. (We refer readers to section II.D. of this final rule with comment period for a detailed discussion of DRG reforms.)

2. Legislative Requirement

Section 5001(c) of Pub. L. 109-171 requires the Secretary to select, by October 1, 2007, at least two conditions that are (a) 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) could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. Section 5001(c) provides that we can revise the list of conditions from time to time, as long as the list contains at least two conditions. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

3. Public Input

In the FY 2007 IPPS proposed rule (71 FR 24100), we sought input from the public regarding conditions with evidence-based guidelines that should be selected in order to implement section 5001(c) of Pub. L. 109-171. The comments that we received were summarized in the FY 2007 IPPS final rule (71 FR 48051 through 48053). In the FY 2008 IPPS proposed rule (72 FR 24716), we again sought formal public comment on conditions that we proposed to select under section 5001(c). As discussed below, in this final rule with comment period, we first summarize the comments we received on the FY 2007 IPPS proposed rule. We then explain our detailed proposals

included in the FY 2008 proposed rule, followed by a summary of the public comments on each condition proposed and our responses to those public comments.

In summary, the majority of the comments that we received in response on the FY 2007 IPPS proposed rule addressed conceptual issues concerning the selection, measurement, and prevention of hospital-acquired infections. Many commenters encouraged CMS to engage in a collaborative discussion with relevant experts in designing, evaluating, and implementing this section. The commenters urged CMS to include individuals with expertise in infection control and prevention, as well as representatives from the provider community, in the discussions.

Many commenters supported the statutory requirement for hospitals to submit information regarding secondary diagnoses present on admission beginning in FY 2008, and suggested that it would better enable CMS and health care providers to more accurately differentiate between comorbidities and hospital-acquired complications. MedPAC, in particular, noted that this requirement was recommended in its March 2005 Report to Congress and indicated that this information is important to Medicare's value-based purchasing efforts. Other commenters cautioned us about potential problems with relying on secondary diagnosis codes to identify hospital-acquired complications, and indicated that secondary diagnosis codes may be an inaccurate method for identifying true hospital-acquired complications.

A number of commenters expressed concerns about the data coding requirement for this payment change and asked for detailed guidance from CMS to help them identify and document hospital-acquired complications. Other commenters expressed concern that not all hospital-acquired infections are preventable and noted that sicker and more complex patients are at greater risk for hospital-acquired infections and complications. Commenters suggested that CMS include standardized infection-prevention process measures, in addition to outcome measures of hospital-acquired infections.

Some commenters proposed that CMS expand the scope of the payment changes beyond the statutory minimum of two conditions. They noted that the death, injury, and cost of hospital-acquired infections are too high to limit this provision to only two conditions. Commenters also recommended that CMS annually select additional hospital

acquired complications for the payment change. Conversely, a number of commenters proposed that CMS initially begin with limited demonstrations to test CMS' methodology before nationwide implementation. One commenter recommended that CMS include appropriate consumer protections to prevent providers from billing patients for the nonreimbursed costs of the hospital-acquired complications and to prevent hospitals from selectively avoiding patients perceived at risk of complications.

In addition to the broad conceptual suggestions, some commenters recommended specific conditions for possible inclusion in the payment changes, which we discussed in detail in the preamble of the proposed rule and in section II.D.4. of this final rule with comment period. We also discuss throughout section II.D. of the preamble of this final rule with comment period other comments that we have considered in developing hospital-acquired conditions that would be subject to reporting.

As it is not addressed elsewhere, we are responding here to the comment about hospitals billing patients for costs of hospital-acquired complications that are not counted as MCCs and CCs.

Section 5001(c) does not make the additional cost of a hospital acquired complication a noncovered cost. The additional costs that a hospital would incur as a result of a hospital-acquired complication remains a covered Medicare cost that is included in the hospital's IPPS payment. Medicare's payment to the hospital is for all inpatient hospital services provided during the stay. The hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication. With respect to the concern about a hospital avoiding patients that are at high risk of complications, we note that the policy is selecting only those conditions that are "reasonably preventable." Thus, we are only selecting those conditions where, if hospital personnel are engaging in good medical practice, the additional costs of the hospital-acquired condition will, in most cases, be avoided and the risk of selectively avoiding patients at high risk of complications will be minimized. **We further note that Medicare's high cost outlier policy is unaffected by section 5001(c). The hospital's total charges for all inpatient services provided during the stay will continue to be used to determine whether the case qualifies for an outlier payment.** Thus, there will continue to be limitations on a hospital's financial risk of treating high

cost cases even if, despite the hospital maintaining good medical practice to avoid complications, a reasonably preventable condition occurs after admission. Finally, as stated further below, we are continuing to work to identify exclusions for situations where the policy should not apply for the selected condition.

4. Collaborative Effort

CMS worked with public health and infectious disease experts from the Centers for Disease Control and Prevention (CDC) to identify a list of hospital-acquired conditions, including infections, as required by section 5001(c) of Pub. L. 109-171. As previously stated, the selected conditions must meet the following three criteria: (a) high cost or high volume or both; (b) result in the assignment of the case to a DRG that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. CMS and CDC staff also collaborated on developing a process for hospitals to submit a Present on Admission (POA) indicator with each secondary condition. The statute requires the Secretary to begin collecting this information as of October 1, 2007. The POA indicator is required in order for us to determine which of the selected conditions developed during a hospital stay. The current electronic format used by hospitals to obtain this information (ASC X12N 837, Version 4010) does not provide a field to obtain the POA information. We issued instructions requiring acute care IPPS hospitals to submit the POA indicator for all diagnosis codes, effective October 1, 2007, through Change Request No. 5499, with a release date of May 11, 2007. The instructions specify how hospitals under the IPPS submit this information in segment K3 in the 2300 loop, data element K301 on the ASC X12N 837, Version 4010 claim. Specific instructions on how to select the correct POA indicator for a diagnosis code are included in the ICD-9-CM Official Guidelines for Coding and Reporting. These guidelines can be found at the following Web site: <http://www.cdc.gov/nchs/datawh/ftp/serv/ftp/cd9/ftp/cd9.htm>.

CMS and CDC staff also received input from a number of groups and organizations on hospital-acquired conditions, including infections. Many of these groups and organizations recommended the selection of conditions mentioned in the FY 2007 IPPS final rule, including the following because of the high cost or high volume

(frequency) of the condition, or both, and because in some cases preventable guidelines already exist:

- Surgical site infections. The groups and organizations stated that there were evidence-based measures to prevent the occurrence of these infections which are currently measured and reported as part of the Surgical Care Improvement Program (SCIP).

- Ventilator-associated pneumonias. The groups and organizations indicated that these conditions are currently measured and reported through SCIP. However, other organizations counseled against selecting these conditions because they believed it was difficult to obtain good definitions and that it was not always clear which ones are hospital acquired.

- Catheter associated bloodstream infections.

- Pressure ulcers.

- Hospital falls. The injury prevention groups included this condition among a group referred to as "serious preventable events," also commonly referred to as "never events" or "serious reportable events." A serious preventable event is defined as a condition which should not occur during an inpatient stay.

- Bloodstream infections/septicemia. Some commenters suggested that we focus on one specific organism, such as staph aureus septicemia.

- Pneumonia. Some commenters recommended the inclusion of a broader group of pneumonia patients, instead of restricting cases to ventilator-associated pneumonias. Some commenters mentioned that while prevention guidelines exist for pneumonia, it is not clear how effective these guidelines may be in preventing pneumonia.

- Vascular catheter associated infections. Commenters indicated that there are CDC guidelines for these infections. Other commenters stated that while this condition certainly deserves focused attention by health care providers, there is not a unique ICD 9 CM code that identifies vascular catheter-associated infections. Therefore, these commenters suggested that there would be difficulty separately identifying these conditions.

- Clostridium difficile-associated disease (CDAD). Several commenters identified this condition as a significant public health issue. Other commenters indicated that, while prevalence of this condition is emerging as a public health problem, there is not currently a strategy for reasonably preventing these infections.

- Methicillin-resistant staphylococcus aureus (MRSA). Several commenters indicated that MRSA has