

through December 31, 2002, for discharges in FY 2002.

## 2. Review of DRGs for CC Split

In an effort to improve the clinical and cost cohesiveness of the DRG classification system, we have evaluated whether additional DRGs should be split based on the presence or absence of a CC. There are currently 116 paired CC split DRGs. We last performed a systematic evaluation and considered changes to the DRGs to recognize the within-DRG cost differences based on the presence or absence of CCs in 1994 (May 27, 1994 IPPS proposed rule, 59 FR 27715). In 1994, we described a refined DRG system based on a list of secondary diagnoses that have a major effect on the resources used by hospitals in treating patients across DRGs. We analyzed how the presence of the secondary diagnosis affected resource use compared to other secondary diagnoses, and classified these secondary diagnoses as non-CC, CC, or major CC. After finalizing the classification of secondary diagnoses, we evaluated which collapsed DRGs should be split on the basis of the presence of a major CC, other CC, or both.<sup>1</sup> However, this refined system was not implemented because we did not believe it would be prudent policy to make changes for which we could not predict the effect on the case-mix (the average DRG relative weight for all cases) and, thus, payments (60 FR 29209). We were concerned that we would be unable to fulfill the requirement of section 1886(d)(4)(C)(iii) of the Act that aggregate payments may not be affected by DRG reclassification and recalibration of weighting factors. That is, our experience has been that

hospitals respond to major changes to the DRGs by changing their coding practices in ways that increase total payments (for example, by beginning to include ICM-9-CM codes that previously did not affect payment for a case). Because changes in coding behavior do not represent a real increase in the severity of the overall mix of cases, total payments should not increase. The only way to ensure this behavioral response does not lead to higher total payments is to make an offsetting adjustment to the system in advance of the fiscal year when the changes are effective.

Section 301(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 Public Law 106-554 authorized the Secretary to make such a prospective adjustment to the average standardized amounts for discharges occurring on or after October 1, 2001, to ensure the total payment impacts of changes to the DRGs do not result in any more or less total spending than would otherwise occur without the changes (budget neutrality).

Pending a decision whether to replace ICD-9-CM with another classification system, we are not proposing to proceed with implementing a refined DRG system at this time. The refined DRG system discussed in the 1994 **Federal Register** involved a complete and thorough assessment of all of the ICD-9-CM diagnosis codes in order to establish an illness severity level associated with each code. Rather than undertaking the time-consuming process of establishing illness severity levels for all ICD-9-CM codes at this time, we believe the more prudent course would be to delay this evaluation

pending the potential replacement of ICD-9-CM. For example, the National Committee on Health and Vital Statistics (NCHVS) is considering making a recommendation to the Secretary on whether to recommend the adoption of ICD-10-CM and the ICD-10-Procedure Coding System (PCS) as the national uniform standard coding system for inpatient reporting.

In the meantime, we have undertaken an effort to identify groups of DRGs where a CC-split appears most justified. Our analysis identified existing DRGs that meet the following criteria: a reduction in variance in charges within the DRG of at least 4 percent; fewer than 75 percent of all patients in the current DRG would be assigned to the with-CC DRG; and the overall payment impact (higher payments for cases in the with-CC DRG offset by lower payments for cases in the without-CC DRG) is at least \$40 million.

The following four DRGs meet these criteria: DRG 4 (Spinal Procedures) and DRG 5 (Extracranial Vascular Procedures) in MDC 1 (Diseases and Disorders of the Nervous System); DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) in MDC 8 (Diseases and Disorders of the Musculoskeletal and Connective Tissue); and DRG 400 (Lymphoma and Leukemia with Major O.R. Procedure) in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms).

The following data indicate that the presence or absence of a CC was found to have a significant impact on patient charges and average length of stays in these four DRGs.

DRG	Number of cases	Average charges	Average length of stay
DRG 4 (Current)	4,488	\$35,074	7.3
With CC	2,514	46,071	10.0
Without CC	1,974	21,070	3.9
DRG 5 (Current)	64,942	18,613	2.9
With CC	29,296	23,213	4.1
Without CC	35,646	14,833	2.0
DRG 231 (Current)	8,971	20,147	4.9
With CC	4,565	25,948	6.9
Without CC	4,406	14,136	2.9
DRG 400 (Current)	4,275	39,953	9.0
With CC	2,990	49,044	11.2
Without CC	1,285	18,799	4.0

Therefore, we are proposing to establish the following new DRGs: proposed DRG 531 (Spinal Procedures

With CC) and proposed DRG 532 (Spinal Procedures Without CC) in MDC 1; proposed DRG 533 (Extracranial

Vascular Procedures With CC) and proposed DRG 534 (Extracranial Vascular Procedures Without CC) in

<sup>1</sup> The complete description of the analysis was published in the *Health Care Financing Review* (Edwards, N., Honemann, D., Burley, D., Navarro,

M., "Refinement of the Medicare Diagnosis-Related Groups to Incorporate a Measure of Severity,"

*Health Care Financing Review*, Winter 1994, Vol. 16, No. 2, p. 45).