

DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG in the class by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other O.R. procedures" as discussed below.

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER search for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the "other O.R. procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The "other O.R. procedures" class is a group of procedures that are only infrequently related to the diagnoses in the MDC but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing modifications of the surgical hierarchy as set forth below.

At this time, we are proposing to revise the surgical hierarchy for the pre-MDC DRGs, MDC 1 (Diseases and

Disorders of the Nervous System), MDC 5 (Diseases and Disorders of the Circulatory System), MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 17 (Myeloproliferative Disease and Disorders, Poorly Differentiated Neoplasms for Lymphoma and Leukemia) as follows:

- In the pre-MDC DRGs, we are proposing to reorder DRG 513 (Pancreas Transplant) above DRG 512 (Simultaneous Pancreas/Kidney Transplant).

- In MDC 1, we are proposing to reorder DRG 3 (Craniotomy Age 0–17) above DRG 528 (Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage); DRG 528 above DRGs 1 and 2 (Craniotomy Age >17 With and Without CC, respectively); DRGs 1 and 2 above DRGs 529 and 530 (Ventricular Shunt Procedures With and Without CC, respectively); DRGs 529 and 530 above DRGs 531 and 532 (Spinal Procedures With and Without CC, respectively); DRGs 531 and 532 above DRGs 533 and 534 (Extracranial Procedures With and Without CC, respectively); and DRGs 533 and 534 above DRG 6 (Carpal Tunnel Release).

- In MDC 5, we are proposing to reorder DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization With AMI, Heart Failure, or Shock) above DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization Without AMI, Heart Failure, or Shock), and DRG 536 above DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization).

- In MDC 8, we are proposing to reorder DRGs 537 and 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With and Without CC, respectively) above DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur).

- In MDC 17, we are proposing to reorder DRGs 539 and 540 (Lymphoma and Leukemia With Major O.R. Procedure With and Without CC, respectively) above DRGs 401 and 402 (Lymphoma and Non-Acute Leukemia With Other O.R. Procedures With and Without CC, respectively).

11. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these

changes for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we are not proposing to delete any of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).

- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.

- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.

- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.

- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered CCs of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR