

producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under DRG 477. Therefore, we are not proposing to move any procedures from DRG 477 to one of the surgical DRGs.

However, we have identified a necessary proposed change under DRG 468 relating to code 50.29 (Other destruction of lesion of liver). We were contacted by a hospital about the fact that code 50.29 is not currently included in MDC 6 (Diseases and Disorders of the Digestive System). The hospital pointed out that it is not uncommon for patients to have procedures performed on the liver when they are admitted for a condition that is classified in MDC 6. For example, DRGs 170 and 171 (Other Digestive System O.R. Procedures With and Without CC, respectively) in MDC 6 currently include liver procedures such as biopsy of the liver. The hospital disagreed with the assignment of code 50.29 to DRG 468 when performed on a patient with a principal diagnosis in MDC 6. We believe that the commenter is correct and are proposing to assign code 50.29 to DRGs 170 and 171 in MDC 6.

b. Reassignment of Procedures among DRGs 468, 476, and 477. We also annually review the list of ICD-9-CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be reassigned from one of these DRGs to another of these DRGs based on average charges and length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to

analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis or Procedure Codes to MDCs. Based on our review this year, we are not proposing to add any diagnosis codes to MDCs.

However, we have identified several procedures that we propose to move from DRG 468 and add to DRGs 476 and 477 because the procedures are nonextensive:

- 38.21, Biopsy of blood vessel
- 77.42, Biopsy of scapula, clavicle and thorax [ribs and sternum]
- 77.43, Biopsy of radius and ulna
- 77.44, Biopsy of carpals and metacarpals
- 77.45, Biopsy of femur
- 77.46, Biopsy of patella
- 77.47, Biopsy of tibia and fibula
- 77.48, Biopsy of tarsals and metatarsals
- 77.49, Biopsy of other bones
- 92.27, Implantation or insertion of radioactive elements

### 13. Changes to the ICD-9-CM Coding System

As described in section II.B.1. of this preamble, the ICD-9-CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD-9-CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, charged with maintaining and updating the ICD-9-CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The ICD-9-CM Manual contains the list of valid diagnosis and procedure codes. (The ICD-9-CM Manual is available from the Government Printing Office on CD-ROM for \$23.00 by calling (202) 512-1800.) The NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while CMS has lead responsibility for the ICD-9-CM procedure codes

included in the *Tabular List* and *Alphabetic Index for Procedures*.

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2004 at a public meeting held on December 6, 2002, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 10, 2003. Those coding changes are announced later in this section of the preamble. Copies of the Committee procedure minutes of the 2002 meetings can be obtained from the CMS home page at:

<http://www.cms.gov/paymentsystems/icd9/>. The diagnosis minutes are found at: <http://www.cdc.gov/nchs/icd9.htm>. Paper copies of these minutes are no longer available and the mailing list has been discontinued.

The first of the 2003 public meetings was held on April 3, 2003. In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include all proposals discussed and approved at the April meeting as part of the code revisions effective the following October. Because this proposed rule is being published after the April meeting, we are able to include all new codes that were approved subsequent to that meeting in Table 6F of the Addendum to this proposed rule, including the DRG assignments.

For a report of procedure topics discussed at the April 2003 meeting, see the Summary Report at: <http://www.cms.hhs.gov/paymentsystems/icd9/>. For a report of the diagnosis topics discussed at the April 2003 meeting, see the Summary Report at: <http://www.cdc.gov/nchs/icd9.htm>.