

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD-9-CM Coordination and Maintenance Committee; NCHS; Room 2404, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD-9-CM Coordination and Maintenance Committee; CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care; C4-08-06; 7500 Security Boulevard; Baltimore, MD 21244-1850. Comments may be sent by E-mail to: pbrooks@cms.hhs.gov.

The ICD-9-CM code changes that have been approved will become effective October 1, 2003. The new ICD-9-CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD-9-CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed DRG classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the Grouper beginning with discharges occurring on or after October 1, 2003. Table 6D contains invalid procedure codes. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes a revised procedure code title for FY 2003.

The Department of Health and Human Services has been actively working on the development of new coding systems to replace the ICD-9-CM. For example, the ICD-10-CM (for diagnoses) and the ICD-10-PCS (for procedures) were developed to replace ICD-9-CM. These efforts have become increasingly important because of the many problems with the ICD-9-CM, which was implemented 24 years ago.

Implementing ICD-10-PCS as a national standard was discussed at the December 6, 2002, ICD-9-CM Coordination and Maintenance Committee meeting. A complete report of the meeting, including examples of letters supporting and opposing ICD-10-PCS, can be found at the CMS web site: www.cms.hhs.gov/paymentsystems/icd9/. Also, the Secretary has asked the NCVHS to recommend whether or not the country should replace ICD-9-CM as a national coding standard with ICD-10-CM and ICD-10-PCS. A complete report on the activities of this committee can be found at: <http://www.ncvhs.hhs.gov>.

14. Other Issues

In addition to the specific topics discussed in section II.B.1. through 13. of this proposed rule, we considered a number of other DRG-related issues. Below is a summary of the issues that were addressed.

a. Cochlear Implants. Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49 (Major Head and Neck Procedures) in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). This is the highest weighted surgical DRG in MDC 3. However, commenters have contended that this DRG is clinically and economically inappropriate and have requested a specific DRG for cochlear implants. The commenters contend that, like heart assist systems (we created a new DRG last year, DRG 525 (Heart Assist System Implant) in MDC 5), cochlear implants are low incidence procedures with disproportionately high costs compared to other procedures within DRG 49.

As we stated in the FY 2003 final rule in our discussion regarding the creation of DRG 525 (67 FR 49989), we found 185 heart assist system cases in DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and 90 cases in DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization). The average charges for these cases were approximately \$36,000 and \$85,000, higher than the average charges for cases in DRGs 104 and 105, respectively, but they represented only a small fraction of all cases in these DRGs (1.3 percent and 0.5 percent, respectively). Therefore, despite the drastically higher average charges for heart assist systems, the relative volume was insufficient to affect the DRG weight to any great degree.

In our analysis of the FY 2002 MedPAR file, we found 134 cochlear implant cases out of 1,637 cases

assigned to DRG 49, which represent more than 8 percent of the total cases in DRG 49. Compared to the situation with the heart assist system implant cases in DRGs 104 and 105, cochlear implants do have a greater effect on the relative weight for DRG 49. Also, while average charges for cochlear implant cases are significantly more than other cases in DRG 49 (average charges for cochlear implant cases were \$51,549 compared to \$25,052 for noncochlear implant cases), this difference is much less than the \$36,000 and \$85,000 differences for heart assist systems cited above.

Although we are concerned about the disparity between the average costs and payments for cochlear implant patients, we also have concerns about establishing a separate DRG for these cases. Doing so could create an incentive for some of these procedures to be shifted from outpatient settings, where most are currently performed. Even among current cochlear implant cases, our analysis found the average length of stay for Medicare patients receiving this procedure in the inpatient setting was just over 1 day, indicating minimal inpatient care is necessary for these cases. It is unclear whether a shift toward more inpatient stays would be appropriate.

We also are concerned whether the volume of cochlear implant cases across all hospitals performing this procedure warrants establishing a new DRG. The DRG relative weights reflect an average cost per case, with the costs of some procedures above the DRG mean costs and some below the mean. It is expected that hospitals will offset losses for certain procedures with payment gains for other procedures, while responding to incentives to maintain efficient operations. An excessive proliferation of new DRGs for specific technologies would fundamentally alter this averaging concept.

Accordingly, for the reasons cited above, we are not proposing to change the DRG assignment of cochlear implants at this time. However, we encourage public comments as to whether a new DRG for cochlear implants (or some other solution) is warranted.

b. Burn Patients on Mechanical Ventilation. Concerns have been raised by hospitals treating burn patients that the current DRG payment for burn patients on mechanical ventilation is not adequate. The DRG assignment for these cases depends on whether the hospital performed the tracheostomy, or the tracheostomy was performed prior to transfer to the hospital. If the hospital does not actually perform the tracheostomy, the case is assigned to