

After cases are screened through the MCE and assigned to a DRG by the GROUPER, a base DRG payment is calculated by the PRICER software. The PRICER calculates the payments for each case covered by the IPPS based on the DRG relative weight and additional factors associated with each hospital, such as IME and DSH adjustments. These additional factors increase the payment amount to hospitals above the base DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider the feasibility of using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

Many of the changes to the DRG classifications are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible inclusion in the next proposed rule and so any proposed changes may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the DRG recalibration process, concerns about DRG classification issues should be brought to our attention no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

In the May 19, 2003 proposed rule, we proposed numerous changes to the DRG classification system for FY 2004. The changes we proposed to the DRG classification system for FY 2004, the public comments we received concerning the proposed changes, the

final DRG changes, and the methodology used to recalibrate the DRG weights are set forth below. The changes we are implementing in this final rule will be reflected in the revised FY 2004 GROUPER version 21.0 and effective for discharges occurring on or after October 1, 2003. Unless otherwise noted in this final rule, our DRG analysis is based on data from the March 2002 update of the FY 2002 MedPAR file, which contains hospital bills received through March 31, 2002, for discharges in FY 2002.

2. Review of DRGs for a Split Based on Presence or Absence of a CC

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 DRGs that reflect a split based on the presence or absence of a CC. 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 the May 27, 1994 IPPS proposed rule, we described a refined DRG system based on a list of secondary diagnoses that have a major effect on the resources that hospitals use to treat 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 based on the presence of a major CC, other CC, or both.¹ However, we did not implement this refined system 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 ICD-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. We believe that 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 for which the changes are effective.

Section 301(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 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).

We are not proceeding with implementing a refined DRG system at this time, pending a decision whether to replace the ICD-9-CM coding system with another classification system. The refined DRG system discussed in the May 1994 IPPS proposed rule 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 the 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 additional 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

¹ 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).