

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 on average lengths of stay 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 proposed 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 Procedures With CC) (the proposed rule incorrectly included "Vascular" in the title) and proposed DRG 534 (Extracranial Procedures Without CC) (the proposed rule incorrectly included "Vascular" in the title) in MDC 1; proposed DRG 537 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With CC) and proposed DRG 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur Without CC) in MDC 8; and proposed DRG 539 (Lymphoma and Leukemia With Major O.R. Procedure With CC) and DRG 540 (Lymphoma and Leukemia With Major O.R. Procedure Without CC) in MDC 17. We proposed that DRGs 4, 5, 231, and 400 would become invalid.

Comment: Seven commenters supported the proposed expansion of the number of DRGs related to spinal procedures and extracranial vascular procedures and the removal of internal fixation devices. One commenter commended CMS for the proposed change to payments for implanting spinal code stimulation devices. Referring to proposed new DRGs 531 and 532, the commenter stated that most inpatients receiving a spinal cord stimulator implant have a comorbid condition, which adds significantly to the cost of care and can serve as a barrier to patient access. Another commenter specifically supported the new DRGs 533 and 534 for extracranial vascular procedures.

One commenter expressed support for CMS' recognition of cost differences within a given DRG based on the presence or absence of a CC and encouraged CMS to continue to consider secondary diagnoses that can have a substantial effect on hospital resources when restructuring DRGs based on cost considerations.

Response: We appreciate the support for these proposals and are adopting them as final without further modification.

We are establishing new DRGs 531, 532, 533, 534, 537, 538, 539, and 540, effective for discharges occurring on or after October 1, 2003. As a result of establishing these new DRGs, DRGs 4, 5, 231, and 400 are invalid, effective October 1, 2003. We will continue to monitor whether additional DRGs should be split based on the presence or absence of a CC.

3. MDC 1 (Diseases and Disorders of the Nervous System)

a. Revisions of DRGs 1 and 2

In the FY 2003 IPPS final rule, we split DRGs 1 and 2 (Craniotomy Age > 17 With and Without CC, respectively) based on the presence or absence of a CC (67 FR 49986). We have received several proposals related to devices or procedures that are used in a small subset of cases from these DRGs. These proposals argue that the current payment for these devices or procedures under DRGs 1 and 2 is inadequate.

Therefore, we conducted an analysis of the charges for various procedures and diagnoses within DRGs 1 and 2 to assess whether further changes to these DRGs may be warranted. Currently, the average charges for cases assigned to

DRGs 1 and 2 are approximately \$55,000 and \$30,000, respectively. In the May 19, 2003 proposed rule, we proposed to create two separate new DRGs for: (1) cases with an intracranial vascular procedure and a principal diagnosis of an intracranial hemorrhage; and (2) craniotomy cases with a ventricular shunt procedure (absent another procedure). The former set of cases are much more expensive than those presently in DRGs 1 and 2; the latter set of cases are much less expensive.

(1) Intracranial Vascular Procedures

Our analysis indicated that patients with an intracranial vascular procedure and a principal diagnosis of an intracranial hemorrhage were significantly more costly than other cases in DRGs 1 and 2. These patients have an acute condition with a high severity of illness and risk of mortality. There were 917 cases in DRGs 1 and 2 with an intracranial vascular procedure and a principal diagnosis of hemorrhage with average charges of approximately \$113,884, which are much higher than the average charges of DRGs 1 and 2 noted above.

We also found 890 cases that had an intracranial vascular procedure without a principal diagnosis of hemorrhage (for example, nonruptured aneurysms). These cases are generally less acutely ill than those involving ruptured aneurysms, and have a lower risk of mortality. Among these 890 cases, the average charges were approximately \$52,756, which are much more similar to the average charges for all cases in DRGs 1 and 2.