

modification to one of the combination groups (particularly the procedure combinations), we believe we should analyze the impact of a modification to the currently existing types of device, lead, and diagnosis combinations. In the future, we will undertake a close review of DRGs 115 and 116 to determine if additional modifications, such as the one suggested, are needed.

*Comment:* Two commenters supported the proposal to restructure DRG 514 through the creation of new DRGs 535 and 536. One of the commenters supported the division of these new DRGs based on the presence or absence of acute myocardial infarction, heart failure, or shock. However, the commenter believed that this new structure would lead to significant confusion among hospital coders with respect to the coding of CRT-Ds. The commenter stated that hospital coders may be confused when a patient is admitted with one diagnosis, but then develops an acute myocardial infarction, heart failure, or shock after the admission but prior to discharge. In these cases, the acute myocardial infarction, heart failure, or shock would be a secondary diagnosis. The split of DRGs 535 and 536 is based on these conditions when they are the principal diagnosis (reason for the hospital admission). To eliminate the potential for misunderstanding, the commenter requested that the definition of DRG 535 be modified so that patients who receive CRT-D devices are assigned to DRG 535 when an ICD-9-CM diagnosis code for heart failure is present as either a principal or secondary diagnosis.

*Response:* We appreciate the support from the commenters for our proposal to modify DRG 514 through the creation of new DRGs 535 and 536. We note that the issue of coding the implantation of CRT-Ds has been covered through extensive articles in the American Hospital Association's *Coding Clinic for ICD-9-CM*. In the past, the coding of cases with acute myocardial infarction, heart failure, or shock has not been problematic for hospital coding specialists. However, should the DRG modifications lead to coding questions on CRT-D cases, we will ask the American Hospital Association to provide additional guidance in its *Coding Clinic for ICD-9-CM*. Furthermore, the DRG splits for an acute myocardial infarction, heart failure, or shock, which currently are included in DRGs 115 and 116, are based on these conditions being the principal diagnosis. As a result, this is a longstanding DRG logic precedent. We do not believe that replicating the logic used for splitting DRGs 115 and 116 and

using it for DRGs 535 and 536 would create confusion for hospital coders. Rather, we believe hospital coders would easily recognize this type of longstanding DRG logic.

*Comment:* Another commenter supported the proposal to split DRG 514 into DRGs 535 and 536 based on the presence or absence of acute myocardial infarction, heart failure, or shock. The commenter stated that this split would ensure greater consistency within the DRG system and ensure adequate payment to hospitals for the higher costs patients receiving implantable cardioverter-defibrillator implants. However, the commenter recommended that DRG 515 undergo a similar split based on the presence or absence of acute myocardial infarction, heart failure, or shock. The commenter stated that the creation of these additional new DRGs would fully align payment logic across all pacemaker and implantable cardioverter-defibrillator implant devices. The manufacturer also believed that differences between average charges and average length of stay for these cases within DRG 515 would warrant this additional splitting of the DRG.

*Response:* We appreciate the support for the revisions involving DRGs 514, 535, and 536. However, when we examined the data for DRGs 514 and 515, we found that there were almost three times as many cases with an acute myocardial infarction, heart failure, or shock cases in DRG 515 as in DRG 514. Those cases in DRG 514 with a principal diagnosis of an acute myocardial infarction, heart failure, or shock, had average charges approximately 20 percent greater than the average charges for all cases in DRG 514. However, cases with a principal diagnosis of an acute myocardial infarction, heart failure, or shock in DRG 515 had average charges that were only about 10 percent greater than all cases in this DRG. Therefore, there is a significantly greater need for the DRG split for DRG 514. We will continue to examine cases within this area, and specifically DRG 515, to determine if additional DRG refinements are needed in the future.

*Comment:* One commenter, who supported the revisions to DRG 514 through the new DRGs 535 and 536, expressed concern about our coverage decisions on automatic implantable cardioverter-defibrillators. The commenter believed the coverage was extremely restricted.

*Response:* We appreciate the support of the commenter for new DRGs 535 and 536. We will share the concerns relating to coverage decisions on automatic implantable cardioverter-defibrillators with our coverage staff.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

Prior to the issuance of the proposed rule, we received a comment that two codes for cervical fusion of the spine are not included within DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC).

The two cervical fusion codes are:

- 81.01, Atlas-axis spinal fusion
- 81.31, Refusion of atlas-axis

The atlas-axis includes the first two vertebrae of the cervical spine (C1 and C2). These two cervical fusion codes are currently assigned to DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC). Because codes 81.01 and 81.31 involve the cervical spine, we proposed to remove these codes from DRGs 497 and 498 and reassign them to DRGs 519 and 520.

We did not receive any comments on this proposal. Therefore, we are adopting as final our proposal to remove codes 81.01 and 81.31 from DRGs 497 and 498 and reassign them to DRGs 519 and 520, effective for FY 2004.

6. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

a. Nonneonate Diagnoses

As indicated earlier, ICD-9-CM diagnosis codes are assigned to MDCs based on 25 groupings corresponding to a single organ system or etiology and, in general, are associated with a particular medical specialty. MDC 15 is comprised of diagnoses that relate to newborns and other neonates with conditions originating in the perinatal period. Some of the codes included in MDC 15 consist of conditions that originate in the neonatal period but can persist throughout life. These conditions are referred to as congenital anomalies. When an older (not neonate) population is treated for a congenital anomaly, DRG assignment problems can arise. For instance, if a patient is over 65 years old and is admitted with a congenital anomaly, it is not appropriate to assign the patient to a newborn DRG. This situation occurs when a congenital anomaly code is classified within MDC 15.

Prior to the publication of the proposed rule, we received a recommendation to move the following congenital anomaly codes from MDC 15 and reassign them to other appropriate MDCs based on the body system being treated:

- 758.9, Chromosome anomaly, not otherwise specified
- 759.4, Conjoined twins