

was present, our analysis was inconclusive due to the wide range of cases identified (1,179 cases across in 136 DRGs). However, recent data collected by the industry on 30 Medicare beneficiaries who received high-dose IL-2 therapy during FY 2002 show average charges for these cases of approximately \$54,000.

Depending on the principal diagnosis reported, patients receiving high-dose IL-2 therapy may be assigned to one of the following five DRGs: DRG 272 (Major Skin Disorder With CC) and DRG 273 (Major Skin Disorder Without CC) in MDC 9; DRG 318 (Kidney and Urinary Tract Neoplasms With CC) and DRG 319 (Kidney and Urinary Tract Neoplasms Without CC) in MDC 11; and DRG 410 (Chemotherapy Without Leukemia as Secondary Diagnosis) in MDC 17. The following table illustrates the average charges for patients in these DRGs.

DRG	Average charges
272 .....	\$14,997
273 .....	9,128
318 .....	16,892
319 .....	9,583
410 .....	16,103

Because of the need to identify the subset of patients receiving this type of treatment, the ICD-9-CM Coordination and Maintenance Committee determined, based on its consideration at the December 6, 2002 public meeting, that a new code for high-dose IL-2 therapy was warranted. Therefore, a new code has been created in the 00 Chapter of ICD-9-CM (Procedures and Interventions, Not Elsewhere Classified), in category 00.1 (Pharmaceuticals) at 00.15 (High-dose infusion Interleukin-2 (IL-2)). The code is effective for cases discharged on or after October 1, 2003.

We believe patients receiving high-dose IL-2 therapy are clinically similar to other cases currently assigned to DRG 492 (Chemotherapy With Acute Leukemia as Secondary Diagnosis) in MDC 17. The average charge for patients currently assigned to DRG 492 is \$55,581. Currently, DRG 492 requires one of the following two principal diagnoses:

- V58.1, Encounter for chemotherapy
- V67.2, Followup examination following chemotherapy

And one of the following secondary diagnoses:

- 204.00, Acute lymphoid leukemia without mention of remission
- 204.01, Acute lymphoid leukemia with remission

- 205.00, Acute myeloid leukemia without mention of remission
- 205.01, Acute myeloid leukemia with remission
- 206.00, Acute monocytic leukemia without mention of remission
- 206.01, Acute monocytic leukemia with remission
- 207.00, Acute erythremia and erythroleukemia without mention of remission
- 207.01, Acute erythremia and erythroleukemia with remission
- 208.00, Acute leukemia of unspecified cell type without mention of remission
- 208.01, Acute leukemia of unspecified cell type without mention of remission

We proposed to modify DRG 492 by adding new procedure code 00.15 to the logic. We indicated that assignment to this DRG would require the same two V-code principal diagnosis codes listed above (V58.1 and V67.2), but would require either one of the leukemia codes listed as a secondary diagnosis, or would require the procedure code 00.15. In addition, we proposed to change the title of DRG 492 to "Chemotherapy With Acute Leukemia or With Use of High Dose Chemotherapy Agent".

In the proposed rule, we indicated that we would monitor cases with procedure code 00.15 as these data became available, and consider potential further refinements to DRG 492 as necessary.

*Comment:* Five commenters supported our proposed change. One commenter who opposed the proposed change believed that classifying high-dose IL-2 therapy as chemotherapy would be a violation of coding advice published in the American Hospital Association's coding publication, *Coding Clinic for ICD-9-CM*, because IL-2 therapy is a biologic response modifier and is considered immunotherapy, not chemotherapy. Therefore, the commenter asserted that the use of either V58.1 or V67.2 as principal diagnosis codes for these cases would result in erroneous coding advice. The commenter added that *Coding Clinic, Fourth Quarter*, page 51, indicates that when a patient is admitted for immunotherapy, the code for the neoplasm should be assigned as the principal diagnosis.

*Response:* We acknowledge the commenter's points concerning correct selection of principal diagnosis, as well as the advice published previously in *Coding Clinic*. However, the discussion of this topic has raised some concerns among the Cooperating Parties of AHA's Editorial Advisory Board. The advice given in the Fourth Quarter 1994 *Coding*

*Clinic* predates the new treatment technology now available, which calls into question the correctness of the published advice. Therefore, this topic will be included on the agenda of an upcoming AHA Editorial Advisory Board meeting for further discussion and clarification. It is likely that new instructions will be issued in the next several months to clarify these coding instructions.

Therefore, in anticipation of this clarification, we are adopting as final the proposed changes to DRG 492. We will continue to monitor this DRG for shifts in resource consumption and validity of DRG assignment, and will specifically monitor code 00.15 for appropriate placement in DRG 492.

8. MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services)

#### a. Implantable Devices

Prior to the publication of the proposed rule, we received a comment regarding three ICD-9-CM diagnosis codes that are currently assigned to MDC 23: V53.01 (Fitting and adjustment of cerebral ventricular (communicating) shunt); V53.02 (Neuropacemaker (brain) (peripheral nerve) (spinal cord)); and V53.09 (Fitting and adjustment of other devices related to nervous system and special senses). The commenter suggested that we move these three codes from MDC 23 to MDC 1 (Diseases and Disorders of the Nervous System) because these codes are used as the principal diagnosis for admissions involving removal, replacement, and reprogramming of devices such as cerebral ventricular shunts, neurostimulators, intrathecal infusion pumps and thalamic stimulators.

Currently, if these diagnosis codes are reported alone without an O.R. procedure, the case would be assigned to DRG 467 (Other Factors Influencing Health Status). However, if an O.R. procedure is reported with the principal diagnosis of V53.01, V53.02, or V53.09, the case would be assigned to DRG 461 (O.R. Procedure with Diagnoses of Other Contact with Health Services).

In our analysis of the MedPAR data, we found 30 cases assigned to DRG 467 and 179 cases assigned to DRG 461 with one of these codes as principal diagnosis. We found that the procedures reported with one of these diagnosis codes were procedures in MDC 1. The most frequent procedure was 86.06 (Insertion of totally implantable infusion pump).

Because the procedures that are routinely used with these codes are in MDC 1, we believe it would be