

change in the surgical hierarchy. Another commenter requested a change in the surgical hierarchy for a case in which a spinal fusion with subsequent debridement is performed during the same admission. This case is assigned to DRG 217 (Wound Debridement and Skin Graft Except Hand, for Musculoskeletal and Connective Tissue Disease). The commenter requested that this case be reassigned to DRG 497 (Spinal Fusion Except Cervical With CC) because it has a higher DRG weight than DRG 217.

*Response:* The surgical hierarchy places a patient with multiple procedures in the most resource intensive class, but this does not necessarily mean that the patient is assigned to the most resource intensive DRG. In this scenario, one surgical class is actually one DRG, and another surgical class is back and neck procedures. These classes encompass 7 DRGs (DRGs 496–500 and DRGs 519 and 520). The average charges for DRG 217 are approximately \$15,000 more than the back and neck procedures class. DRG 217 is hierarchically ordered higher in the surgical group than DRG 497, which is the reason the case is assigned to DRG 217.

Therefore, we are adopting the proposed changes in MDCs 1, 5, 8, and 17 as final. We are not making any changes in the pre-MDC DRGs.

#### 11. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list. As we proposed in the May 19, 2003 proposed rule, we are not deleting any of the diagnosis codes on the CC list.

As explained in the May 19, 1989 proposed rule (52 FR 18877) and the September 1, 1987 final notice (52 FR

33154), the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another.
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.<sup>3</sup>

We proposed a limited revision of the CC Exclusions List to take into account the proposed changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2003. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) We proposed these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this final rule contain the revisions to the 13 CC Exclusions List that will be effective for discharges occurring on or after October 1, 2003. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an

<sup>3</sup> See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions; the August 1, 2000 final rule (65 FR 47064) for the FY 2001 revisions; the August 1, 2001 final rule (66 FR 39851) for the FY 2002 revisions; and the August 1, 2002 final rule (67 FR 49998) for the FY 2003 revisions. In the July 30, 1999 final rule (64 FR 41490), we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2003, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2003, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

*Comment:* One commenter indicated that it was unable to provide meaningful comments on Tables 6G and 6H because of formatting errors in the printed tables. In addition, the commenter suggested that the changes in the tables should not be effective until a revised version was made available for public comment.

*Response:* We apologize for the errors in the format of the tables, which were printer's errors. However, we note that the tables did contain the correct codes, even though the format of the columns was distorted. Therefore, we do not believe a delay in the effective date of the changes is warranted.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for \$133.00 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2002, and 2003) and those in Tables 6G and 6H of this final rule for FY 2004 must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2003. (**Note:** There was no CC Exclusions List in FY 2001 because we did not make changes to the ICD–9–CM codes for FY 2001.)

Alternatively, the complete documentation of the GROUPER logic,