

including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROPER program. The current DRG Definitions Manual, Version 20.0, is available for \$225.00, which includes \$15.00 for shipping and handling. Version 21.0 of this manual, which includes the final FY 2004 DRG changes, is available for \$225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949-0303. Please specify the revision or revisions requested.

12. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0 Incision of prostate
- 60.12 Open biopsy of prostate
- 60.15 Biopsy of periprostatic tissue
- 60.18 Other diagnostic procedures on prostate and periprostatic tissue
- 60.21 Transurethral prostatectomy
- 60.29 Other transurethral prostatectomy
- 60.61 Local excision of lesion of prostate
- 60.69 Prostatectomy, not elsewhere classified
- 60.81 Incision of periprostatic tissue
- 60.82 Excision of periprostatic tissue
- 60.93 Repair of prostate
- 60.94 Control of (postoperative) hemorrhage of prostate
- 60.95 Transurethral balloon dilation of the prostatic urethra
- 60.99 Other operations on prostate

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in

which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD-9-CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962); in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496); in FY 2001, as noted in the August 1, 2000 final rule (65 FR 47064); or in FY 2002, as noted in the August 1, 2001 final rule (66 FR 39852). In the August 1, 2002 final rule (67 FR 49999), we did not move any procedures from DRG 477. However, we did move procedures codes from DRG 468 and placed them in more clinically coherent DRGs.

a. Moving Procedure Codes From DRG 468 or DRG 477 to MDCs

We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under DRG 477. Therefore, we did not propose moving any procedures from DRG 477 to one of the surgical DRGs in this final rule.

However, in the proposed rule, we identified a necessary proposed change under DRG 468 relating to code 50.29 (Other destruction of lesion of liver). We

were contacted by a hospital about the fact that code 50.29 is not currently included in MDC 6 (Diseases and Disorders of the Digestive System). The hospital pointed out that it is not uncommon for patients to have procedures performed on the liver when they are admitted for a condition that is classified in MDC 6. For example, DRGs 170 and 171 (Other Digestive System O.R. Procedures With and Without CC, respectively) in MDC 6 currently include liver procedures such as biopsy of the liver. The hospital disagreed with the assignment of code 50.29 to DRG 468 when performed on a patient with a principal diagnosis in MDC 6. We believe that the commenter is correct. Therefore, we proposed to assign code 50.29 to DRGs 170 and 171 in MDC 6.

We received several comments of support for our proposal to assign code 50.29 to DRGs 170 and 171 in MDC 6. Therefore, we are adopting the proposal as final without modification. As a result, code 50.29 will not result in assignment to DRG 468 when this procedure is performed on patient with a principal diagnosis in MDC 6.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

We also annually review the list of ICD-9-CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be reassigned from one of these three DRGs to another of the three DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we did not propose moving any procedures from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

However, in the proposed rule, we identified several procedures that we proposed to move from DRG 468 and add to DRGs 476 and 477 because the procedures are nonextensive:

- 38.21, Biopsy of blood vessel
- 77.42, Biopsy of scapula, clavicle and thorax [ribs and sternum]
- 77.43, Biopsy of radius and ulna
- 77.44, Biopsy of carpals and metacarpals
- 77.45, Biopsy of femur
- 77.46, Biopsy of patella