

Table 6A of the Addendum to the proposed rule. We had proposed assigning this new code to MDC 12 (Diseases and Disorders of the Male Reproductive System), and DRG 352 (Other Male Reproductive System Diagnoses). The commenter pointed out that this new code could apply to both males and females. Its predecessor code was assigned to MDC 12, DRG 352, as well as to MDC 13 (Diseases and Disorders of the Female Reproductive System) and DRGs 358 (Uterine and Adnexa Procedure for Non-Malignancy with CC), 359 (Uterine and Adnexa Procedure for Non-Malignancy without CC), and 369 (Menstrual and Other Female Reproductive System Disorders).

Response: The commenter is correct. Diagnosis code 752.89 would apply to both males and females and should have been included in both MDC 12 and MDC 13. In this final rule, we are assigning diagnosis code 752.89 to MDC 13 under DRGs 358, 359, and 369 and have modified Table 6A of the Addendum to this final rule accordingly.

Comment: One commenter pointed out a typographical error for the code title for V15.87. The commenter indicated that the word "membrane" should be changed to "membrane"; that is, the title should read "History of Extracorporeal Membrane Oxygenation (ECMO)."

Response: We agree with the commenter and have corrected the title in Table 6A of the Addendum to this final rule.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPE beginning with discharges occurring on or after October 1, 2003. Table 6D contains invalid procedure codes. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2004.

The Department of Health and Human Services has been actively working on the development of new coding systems to replace the ICD-9-CM. In December 1990, the National Committee on Vital and Health Statistics (NCVHS) issued a report noting that, while the ICD-9-CM classification system had been responsive to changing technologies and

identifying new diseases, there was concern that the ICD classification might be stressed to a point where the quality of the system would soon be compromised. The ICD-10-CM (for diagnoses) and the ICD-10-PCS (for procedures) were developed in response to these concerns. These efforts have become increasingly important because of the growing number of problems with the ICD-9-CM, which was implemented 24 years ago.

Implementing ICD-10-PCS as a national standard was discussed at the December 6, 2002, ICD-9-CM Coordination and Maintenance Committee meeting. A complete report of the meeting, including examples of letters supporting and opposing ICD-10-PCS, can be found at the CMS Web site: <http://www.cms.hhs.gov/paymentsystems/icd9/>. Also, the Secretary has asked the NCVHS to recommend whether or not the country should replace ICD-9-CM as a national coding standard with ICD-10-CM and ICD-10-PCS. A complete report on the activities of this committee can be found at: <http://www.ncvhs.hhs.gov>.

Comment: Several commenters supported the move to ICD-10-CM and ICD-10-PCS as national coding standards. One commenter representing hospitals supported moving to these systems expeditiously. The commenter stated that ICD-10-CM and ICD-10-PCS are a vast improvement over ICD-9-CM and would provide greater specificity and detail in coding. Another commenter believed that the new systems would offer immediate and long-term benefits for specifying illness severity and accommodating a diverse array of new technologies that warrant expedited assignment under the DRG system.

Response: We appreciate the support from many in the health care industry for ICD-10-CM and ICD-10-PCS. We agree with the importance of having and maintaining medical coding systems that accurately capture the patient's conditions and medical procedures. We also agree that ICD-9-CM is seriously constrained because of its structure and space limitations. We recognize that over 30 countries have implemented ICD-10 to better capture medical conditions. Countries such as Canada and Australia have successfully implemented ICD-10 without serious ramifications to their data or reimbursement systems. We agree that it is important to capture information on new technologies. It is becoming increasingly difficult to do so using ICD-9-CM. We will continue working with NCVHS and the health care industry to determine if these new

systems should be named as national coding standards.

14. Other Issues

In addition to the specific topics discussed in section II.B.1. through 13. of this preamble, we considered a number of other DRG-related issues in the May 19, 2003 proposed rule. Below is a summary of the issues that were addressed.

a. Cochlear Implants

Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49 (Major Head and Neck Procedures) in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). This is the highest weighted surgical DRG in MDC 3. However, prior to the publication of the proposed rule, commenters contended that this DRG assignment is clinically and economically inappropriate for cochlear implants and requested a more specific DRG. The commenters contend that, like heart assist systems (for which we created a new DRG last year, DRG 525 (Heart Assist System Implant) in MDC 5), cochlear implants are low incidence procedures with disproportionately high costs compared to other procedures within DRG 49.

As we stated in the FY 2003 final rule in our discussion regarding the creation of DRG 525 (67 FR 49989), we found 185 heart assist system cases in DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and 90 cases in DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization). The average charges for these cases were approximately \$36,000 and \$85,000 higher than the average charges for cases in DRGs 104 and 105, respectively. However, these cases represented only a small fraction of all cases in these DRGs (1.3 percent and 0.5 percent, respectively). Therefore, despite the drastically higher average charges for heart assist systems, the relative volume was insufficient to affect the DRG weight to any great degree.

In our analysis of the FY 2002 MedPAR file, we found 134 cochlear implant cases out of 1,637 cases assigned to DRG 49, which represent more than 8 percent of the total cases in DRG 49. Compared to the situation with the heart assist system implant cases in DRGs 104 and 105, cochlear implants do have a greater effect on the relative weight for DRG 49. Also, while average charges for cochlear implant cases are significantly more than other cases in DRG 49 (average charges for cochlear implant cases were \$51,549 compared to