

\$25,052 for noncochlear implant cases), this difference is much less than the \$36,000 and \$85,000 differences for heart assist systems cited above.

Although we are concerned about the disparity between the average costs and payments for cochlear implant patients, we also have concerns about establishing a separate DRG for these cases. Doing so could create an incentive for some of these procedures to be shifted from outpatient settings, where most are currently performed. Even among current cochlear implant cases, our analysis found the average length of stay for Medicare patients receiving this procedure in the inpatient setting was just over 1 day, indicating minimal inpatient care is necessary for these cases. It is unclear whether a shift toward more inpatient stays would be appropriate.

We also are concerned whether the volume of cochlear implant cases across all hospitals performing this procedure warrants establishing a new DRG. The DRG relative weights reflect an average cost per case, with the costs of some procedures above the DRG mean costs and some below the mean. It is expected that hospitals will offset losses for certain procedures with payment gains for other procedures, while responding to incentives to maintain efficient operations. An excessive proliferation of new DRGs for specific technologies would fundamentally alter this averaging concept.

Accordingly, for the reasons cited above, we did not propose to change the DRG assignment of cochlear implants in the May 19, 2003 proposed rule. However, we did encourage public comments as to whether a new DRG for cochlear implants (or some other solution) is warranted.

Comment: Several commenters urged CMS to reassign cochlear implantation procedures to a DRG that has a weight appropriate to reflect the costs of cochlear implantation. The commenters stated that while a hospital's acquisition cost of the device itself averages approximately \$23,800, the proposed payment for FY 2004 is approximately \$8,233. While most cochlear implants have been and will continue to be performed on an outpatient basis, a small, but significant portion, particularly for Medicare beneficiaries, need to be conducted as an inpatient procedure. The commenters stated that the low volume of inpatient cases is a direct result of the inadequate payment rate.

The commenters stated that cochlear implantation is clinically incongruent and economically inconsistent with the other procedures in DRG 49. The

commenters believed that cochlear implants do not meaningfully affect the weighting of DRG 49 and proposed two options: Create a new DRG specifically for cochlear implants, or reassign cochlear implants cases to DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses).

Response: We requested public input on possible solutions for these cases because we recognize the data indicate the charges for these cases are much higher than for other cases in DRG 49. However, we are concerned that the options suggested by commenters are not workable solutions. As we alluded to in the proposed rule, we have concerns about creating a new DRG for this procedure. We appreciate the point made by commenters that only those patients requiring inpatient care would receive the procedure in an inpatient setting, even if the DRG payment were increased. However, as we have stated previously, we are reluctant to create new DRGs for specific, low-volume procedures. Doing so would create a proliferation of DRGs and a loss of some of the efficiency incentives inherent in the current system. Hospitals are generally able to offset any losses on such procedures through corresponding payment advantages from other, less expensive procedures.

The second option suggested, to reassign these cases to DRG 482, is inconsistent with the structure of that DRG, which requires that a tracheostomy be performed in order to be assigned to this DRG. Assigning cochlear implants to this DRG would fundamentally alter its structure, which could not be done without first proposing such a change for public review and comment.

However, as we indicated above, we recognize the disparity in average charges for these cases compared to other cases in DRG 49, and will continue to evaluate possible reclassification options for FY 2005.

b. Burn Patients on Mechanical Ventilation

Prior to the publication of the proposed rule, concerns were raised by hospitals treating burn patients that the current DRG payment for burn patients on mechanical ventilation is not adequate. The DRG assignment for these cases depends on whether the hospital performed the tracheostomy, or the tracheostomy was performed prior to transfer to the hospital. If the hospital does not actually perform the tracheostomy, the case is assigned to one of the burn DRGs in MDC 22 (Burns). If the hospital performs a tracheostomy, the case is assigned to

DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses) or DRG 483 (Tracheostomy with Mechanical Ventilation 96 + Hours, Except Face, Mouth and Neck Diagnoses).

In the August 1, 2002 final rule, we modified DRGs 482 and 483 to recognize code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more) for the first time in the DRG assignment (67 FR 49996). We noted that many patients assigned to DRG 483 did not have code 96.72 recorded. We believed this was due, in part, to the limited number of procedure codes (six) that can be submitted on the current billing form, and the fact that code 96.72 did not affect the DRG assignment (prior to FY 2003). We stated that we would give future consideration to further modifying DRGs 482 and 483 based on the presence of code 96.72. We anticipate that cases of patients receiving 96 or more hours of continuous mechanical ventilation are more expensive than other tracheostomy patients. Once code 96.72 is reported more frequently, we will be better able to assess the need for future revisions to DRGs 482 and 483.

To assess the payment for burn patients on mechanical ventilation when the hospital did not perform the tracheostomy, we analyzed data on cases reporting both code 96.72 and diagnosis code V44.0 (Tracheostomy status). We had hoped that these cases would show patients on long-term ventilation who were admitted to the hospital with a tracheostomy in place. Our data did not include any cases reported in any of the burn DRGs with codes 96.72 and V44.0. We then analyzed data on the frequency of cases reporting code 96.72 along with diagnosis code V46.1 (Respirator dependence). We found only 5 of these cases in the burn DRGs. With so few cases reporting code 96.72, it is difficult for us to determine the effect of long-term ventilation on reimbursement for burn cases.

All hospitals, including those that treat burn patients, are encouraged to increase the reporting of code 96.72 for patients who are on continuous mechanical ventilation for 96 or more hours. With better data, we would be able to determine how best to make any future DRG modification for all patients on long-term mechanical ventilation.

We received one comment from an organization representing coders that agreed with the importance of reporting code 96.72 and the need for further education on this issue. We will continue to monitor our data to assess