

170 and DRG 171 are higher weighted than DRGs 157 and 158.

In the May 19, 2003 proposed rule, we did not propose to assign these cases to DRGs 170 and 171. Although we recognized that the data submitted by the commenter appear to show this procedure is associated with above average costs in the DRGs to which these cases are assigned, we stated that we believe the current assignment is the most clinically appropriate at this time. As noted above, the procedure codes to identify the implantation, revision, or removal of these devices were effective beginning on October 1, 2002. Therefore, we proposed to monitor the costs of these cases using actual Medicare cases with these codes included from the FY 2003 MedPAR that will be used for the FY 2004 DRG relative weights.

*Comment:* Two commenters expressed concern that the procedures for insertion and removal of an artificial anal sphincter are assigned to DRG groupings that do not cover the cost of the device. In addition, one commenter stated that, as the surgeon must operate on two distinct areas of the patient's body, these procedures are more resource-intensive and, therefore, are not clinically coherent with other procedures of low complexity in DRGs 157 and 158.

*Response:* As noted above, the codes describing the implantation, revision, or removal of artificial anal sphincters were created for use beginning on October 1, 2002. Therefore, we do not have data on cases assigned to codes 49.75 and 49.76. Accordingly, we are not making any changes to the DRG assignments of these codes at this time. However, we will continue to monitor this procedure in the upcoming MedPAR data and will, in the future, consider modifications relating to DRG assignment(s) if warranted.

### C. Recalibration of DRG Weights

As we proposed, in this final rule we used the same basic methodology for the FY 2004 recalibration as we did for FY 2003 (August 1, 2002 IPPS final rule (67 FR 50008)). That is, we recalibrated the DRG weights based on charge data for Medicare discharges using the most current charge information available (the FY 2002 MedPAR file).

The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2002 MedPAR data used in this final rule include discharges occurring between October 1, 2001 and September 30, 2002, based on bills received by CMS through March 31, 2003, from all hospitals subject to the IPPS and short-

term acute care hospitals in Maryland (which is under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2002 MedPAR file includes data for approximately 11,496,239 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data excludes CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. This is a change from the recalibration methodology in the proposed rule, where hospitals that subsequently became CAHs were included in the data. In this final rule, we changed the recalibration methodology for consistency with our change that excluded these CAHs from the data used to construct the wage index.

The methodology used to calculate the DRG relative weights from the FY 2002 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions discussed in section II.B. of this preamble.

- The transplant cases that were used to establish the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2000 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)

- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, a transfer

case receiving payment under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.

- Statistical outliers were eliminated by removing all cases that are beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.

- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight.

The new weights are normalized by an adjustment factor (1.45726) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

As noted below in section IV.A.2. of the preamble of this final rule, we are expanding the transfer policy applicable to postacute care transfers to a total of 29 DRGs (the current 10 DRGs, minus 2, plus 21 additional DRGs), beginning in FY 2004. Because we count a transfer case as a fraction of a case as described above in the recalibration process, the expansion of the postacute care transfer policy to additional DRGs affects the relative weights for those DRGs. Therefore, we calculated the final FY 2004 normalization factor comparing: the case-mix using the final FY 2004 DRG relative weights in which we treated postacute care transfer cases in the additional DRGs for the postacute transfer policy for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these additional DRGs as transfer cases.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the final DRG weights for FY 2004. Using the FY 2002 MedPAR data set, there are 42 DRGs that contain fewer than 10 cases. We computed the weights for these low-volume DRGs by adjusting the FY 2003 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

*Comment:* Commenters questioned the fact that the proposed weights for several DRGs declined from the prior fiscal year.

*Response:* As described above, the relative weight for each DRG is