

DRG	DRG title	DRG title care transfer cases	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1998–2003
127	Heart Failure & Shock	196,581	24.18	– 8.89
130	Peripheral Vascular Disorders With CC	29,859	21.92	– 11.76
131	Peripheral Vascular Disorders Without CC	26,455	20.16	– 19.51
209	Major Joint and Limb Reattachment Procedures of Lower Extremity	247,513	29.20	– 15.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC	89,612	46.77	– 6.15
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC	20,584	21.89	– 8.00
236	Fractures of Hip and Pelvis	24,633	11.26	– 6.98
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.	23,184	40.44	– 7.55
277	Cellulitis Age >17 With CC	35,873	36.56	– 7.84
278	Cellulitis Age >17 Without CC	31,857	13.24	– 10.00
294	Diabetes Age >35	29,608	17.65	– 15.00
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC	106,923	29.26	– 9.30
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC	48,116	7.25	– 10.00
320	Kidney and Urinary Tract Infections Age >17 With CC	80,717	27.38	– 8.51
321	Kidney and Urinary Tract Infections Age >17 Without CC	30,934	18.34	– 13.89
395	Red Blood Cell Disorders Age >17	23,053	25.27	– 11.11
429	Organic Disturbances and Mental Retardation	14,731	46.30	– 12.96
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis	25,114	41.26	7.07
483	Tracheotomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	20,034	49.56	2.37

Transfers to postacute care from the DRGs listed in the above table will be included under this policy, effective for discharges occurring on or after October 1, 2003. As a result of our analysis in which we applied the new qualifying criteria, we removed DRG 263 and DRG 264 from the current list of 10 DRGs, and we removed DRG 243 and DRG 462 from the proposed list of additional 19 DRGs. However, we added four new DRGs (that were not included in our proposal) to the policy based on this analysis: DRG 88 (Chronic Obstructive Pulmonary Disease); DRG 127 (Heart Failure and Shock); DRG 294 (Diabetes Age >35); and DRG 395 (Red Blood Cell Disorders, Age >17). We will review and update this list periodically to assess whether additional DRGs should be added or existing DRGs should be removed.

Comment: One commenter contested the automatic inclusion of both DRGs in a paired-DRG combination. The commenter believed any incentive for hospitals not to include a code that would identify a complicating or comorbid condition would be very limited and would have negligible effect on hospital behavior. However, the commenter asserted that if CMS is going to include both DRGs in a paired-DRG combination, CMS must combine the data for the two DRGs when applying the selection criteria.

Response: We include both DRGs from a paired-DRG combination because if we were to include only the “with CC” DRG from a “with/without CC” DRG combination in the transfer policy, there would be an incentive for hospitals not to include any code that

would identify a complicating or comorbid condition. We believe our approach of identifying either DRG from a paired-DRG combination individually for inclusion in the policy is appropriate.

Comment: One commenter argued that DRG 468 should not be included in the policy because of the variation in the types of cases included in this DRG. The commenter pointed out that the cases in the DRG are, by definition, atypical, and the average lengths of stay for procedures included in this DRG vary widely. The commenter noted that “every year CMS makes changes to the list of procedures that are assigned to this DRG. Therefore, a comparison of length of stay over time is not valid because the types of cases in the DRG change every year. The criterion that length of stay must have decreased by 7 percent compared to 1998 cannot be applied to DRG 468.” The commenter added that application of a per diem payment based on a mean length of stay to a DRG that contains such a wide variety of different types of cases will result in extreme inequities.

One commenter argued for the exclusion of DRG 483 from the policy. The commenter argued that due to the large variation of lengths of stay for treatments in this DRG, the transfer policy has a very significant impact on payment for these cases that is unrelated to the use of postacute care.

Response: We disagree that DRG 468 should be excluded from the policy because of the variation in the types of cases within this DRG. Over 40 percent of transfers to postacute care within this DRG occurred before the geometric

mean length of stay. Although it is true the nature of this DRG makes it difficult to assess whether there is a trend to shift care out of the acute care setting into the postacute care setting or there is just a different mix of cases being assigned to this DRG, we believe it is equitable to adjust payments for short-stay cases transferred to postacute care within this DRG. As noted above, application of this policy in the DRG recalibration process results in an overall increase in the payments for other cases in the DRG. Given the heterogeneous nature of this DRG, we believe this is appropriate.

We have addressed similar concerns in the past with respect to the inclusion of DRG 483 in this policy.

Comment: One comment noted that DRGs 121 and 122 should be included in the special payment provision due to the fact that “these cases receive the most resource intensive services within the first day of the stay due to the acute nature of a myocardial infarction * * * [including care in] intensive care units, costly IV drug infusions, and multiple tests and monitoring.”

Response: Based on the revised list of DRGs that meet the criteria as described above, we analyzed which of these DRGs qualified for the special payment methodology. The only DRGs that had charges for short-stay transfer cases on the first day of stay that were greater than 50 percent of the average charges of all cases across the DRG were DRGs 209 and 211 (71 percent and 57 percent, respectively). Because DRG 211 is paired with DRG 210, we included DRG 210 in the payment policy as well (our analysis showed that short-stay transfer cases had 40 percent of costs on the first