Analysis of Final Rule for 2006 Revisions to the Medicare Hospital Inpatient Prospective Payment System

The final rule regarding fiscal year 2006 revisions to the Medicare hospital inpatient prospective payment system (PPS) was published in the August 12, 2005 issue of the Federal Register. This rule becomes effective on October 1, 2005. This analysis covers highlights of the rule that are of particular interest to health information management (HIM) professionals. Changes that were proposed in the proposed rule but not adopted in the final rule are not addressed. The final rule can be reviewed in its entirety by downloading it from this link: http://www.access.gpo.gov/su_docs/fedreg/a050812c.html.

CHANGES TO DRG CLASSIFICATIONS

Strokes (70FR47287)

DRG 559 has been created to capture acute ischemic strokes involving the use of thrombolytic agent.

Centers for Medicare & Medicaid Services’ (CMS’) Rationale: Stroke cases involving the use of a thrombolytic agent are more expensive than cases that don’t involve the use of a thrombolytic agent.

Severity Adjusted Cardiovascular Procedures (70FR47289)

Nine DRGs (107, 109, 111, 116, 478, 516, 517, 526, and 527) have been deleted and replaced with 12 new DRGs (547-558). These new DRGs differentiate cases on the basis of the presence or absence of a major cardiovascular condition. A complete list of the major cardiovascular conditions can be found on page 47477 of the final rule.

CMS’ Rationale: Significant revisions have been made to a number of cardiovascular DRGs that currently contain patients with a wide range of severity and resource consumption in order to reflect more accurately the resources required to care for different kinds of cardiovascular patients.

The table below shows a comparison of the existing and new DRGs:
## MDC 5, Cardiovascular DRG Changes

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<td>Percutaneous Cardiovascular Proc with Drug-eluting Stent w/o AMI</td>
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### Automatic Implantable Cardioverter/Defibrillator (70FR47290)

Code 37.26, Cardiac electrophysiologic stimulation and recording studies (EPS), has been removed from the list of cardiac catheterizations for DRGs 535 and 536 (Cardiac Defibrillator Implant With Cardiac Catheterization) and has been added to DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization).

**CMS’ Rationale:** The data show that when code 37.26 is the only procedure reported from the list of cardiac catheterizations, the average charges and the average length of stay are considerably lower. CMS noted that there is considerable confusion about whether or not code 37.26 should be reported when the procedure is performed as part of the defibrillator implantation. Currently, ICD-9-CM instructs not to report this code when a defibrillator is inserted. Issues regarding the use of code 37.26 will be addressed at an upcoming ICD-9-CM Coordination and Maintenance Committee meeting.

### Coronary Artery Stents (70FR47292)

DRGs 516, 517, 526, and 527 for percutaneous placement of both drug-eluting and non-drug-eluting stents have been deleted and replaced with four new DRGs. Rather than dividing the DRG pairs based on whether the patient had an acute myocardial infarction,
both pairs of the new DRGs are split based on the presence or absence of a major cardiovascular condition. The new DRG titles are:

- DRG 555 (Percutaneous Cardiovascular Procedure with Major Cardiovascular Diagnosis (formerly DRG 516)
- DRG 556 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without Major Cardiovascular Diagnosis (formerly DRG 517)
- 557 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with Major Cardiovascular Diagnosis (formerly DRG 526)
- DRG 558 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without Major Cardiovascular Diagnosis (formerly DRG 527)

**CMS’ Rationale:** This revised structure identifies subgroups of significantly more severe patients who use greater hospital resources more accurately than was possible under the previous DRGs.

**Insertion of Left Atrial Appendage Device (70FR47295)**

Code 35.52, Repair of atrial septal defect with prosthesis, closed technique, has been moved out of DRG 108 (Other Cardiovascular Procedures) and placed in DRG 518 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or Acute Myocardial Infarction).

**CMS’ Rationale:** This change will result in a more coherent group of cases in DRG 518 that reflect all percutaneous procedures.

**External Heart Assist System Implant (70FR47297)**

DRG 103 (Heart Transplant) has been reconfigured such that patients who have both the implantation of the external ventricular assist device (code 37.65) and the explantation of that device (code 37.64) prior to hospital discharge will be assigned to DRG 103. The revised DRG 103 contains the following codes:

- 33.6, Combined heart-lung transplantation
- 37.51, Heart transplantation
- 37.66, Insertion of implantable heart assist system
  OR
- 37.65, Implant of external heart assist system
  AND
- 37.64, Removal of heart assist system

**CMS’ Rationale:** This change will result in higher payments for patients who receive both an implant and an explant of an external heart assist system during a single hospital stay. CMS’ intent in establishing this policy is to recognize the higher costs of patients who have a longer length of stay and are discharged alive with their native heart. Cases in which a heart transplant also occurs during the same hospitalization episode would continue to be assigned to DRG 103.
Extracorporeal Membrane Oxygenation (70FR47301)

Extracorporeal membrane oxygenation (ECMO) cases have been reassigned to DRG 541. The title of DRG 541 has been changed to “ECMO or Tracheostomy with Mechanical Ventilation +96 Hours or Principal Diagnosis Except Face, Mouth, and Neck with Major O.R.” Correspondingly, the title of DRG 542 has been changed to “Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck without Major O.R.”

CMS’ Rationale: The data indicate that DRG 541 would be a more appropriate DRG assignment for cases where ECMO is performed. Also, under the All Payer DRG system used in New York State, cases involving ECMO are assigned to the tracheostomy DRG. Thus, the assignment of ECMO cases to the tracheostomy DRG for Medicare would be similar to how these cases are grouped in another DRG system.

Hip and Knee Replacements (70FR47303)

DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremities) has been deleted and replaced with new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement). Lower extremity reattachments and initial hip and knee replacements are classified to DRG 544, and revisions of hip and knee replacements are classified to DRG 545.

CMS’ Rationale: Revisions are significantly more resource intensive than the original hip and knee replacements.

Multiple Level Spinal Fusions (70FR47306)

New DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy) has been created and will be composed of all noncervical spinal fusions previously assigned to DRGs 497 and 498 (Spinal Fusion Except Cervical with and without CC, respectively) that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy. The principal diagnosis codes that will lead to this DRG assignment are the following:

- 170.2, Malignant neoplasm of bone and articular cartilage, vertebral column, excluding sacrum and coccyx
- 198.5, Secondary malignant neoplasm of bone and bone marrow
- 213.2, Benign neoplasm of bone and articular cartilage, vertebral column, excluding sacrum and coccyx
- 238.0, Neoplasm of uncertain behavior, bone and articular cartilage
- 239.2, Neoplasm of unspecified nature, bone, soft tissue, and skin
- 732.0, Juvenile osteochondrosis of spine
- 733.13, Pathologic fracture of vertebrae
- 737.0, Adolescent postural kyphosis
- 737.10, Kyphosis (acquired) (postural)
- 737.11, Kyphosis due to radiation
- 737.12, Kyphosis, post laminectomy
- 737.19, Kyphosis (acquired), other
- 737.20, Lordosis (acquired) (postural)
- 737.21, Lordosis, post laminectomy
- 737.22, Other postsurgical lordosis
- 737.29, Lordosis (acquired), other
- 737.30, Scoliosis [and kyphoscoliosis], idiopathic
- 737.31, Resolving infantile idiopathic scoliosis
- 737.32, Progressive infantile idiopathic scoliosis
- 737.33, Scoliosis due to radiation
- 737.34, Thoracogenic scoliosis
- 737.39, Other kyphoscoliosis and scoliosis
- 737.8, Other curvatures of spine
- 737.9, Unspecified curvature of spine
- 754.2, Certain congenital musculoskeletal deformities, of spine
- 756.51, Osteogenesis imperfecta

The secondary diagnoses that will lead to the new DRG 546 assignment (these diagnoses cannot be reported as the principal diagnosis because they are manifestation codes) are:
- 737.40, Curvature of spine associated with other conditions, unspecified
- 737.41, Curvature of spine associated with other conditions, kyphosis
- 737.42, Curvature of spine associated with other conditions, lordosis
- 737.43, Curvature of spine associated with other conditions, scoliosis

**CMS' Rationale:** The performance of a spinal fusion for a diagnosis of curvature of the spine or bone malignancy results in a significant increase in resource use.

**Medicare Code Editor (MCE) Changes: Newborn Diagnoses (70FR47312)**

Last year, code 796.6, Abnormal findings on neonatal screening, was inadvertently added to both the MCE edit for “Maternity Diagnoses-Age 12 through 55” and “Diagnoses Allowed for Females Only.” This code has been removed from both of these MCE edits and added to the “Newborn Diagnoses” edit.

**CMS' Rationale:** Code 796.6 was included in this edit in error.

**MCE Changes: Diagnoses Allowed for “Males Only” (70FR47312)**

Codes 257.2, Other testicular hypofunction, and 257.8, Other testicular dysfunction, have been removed from the “males only” MCE edit.
**CMS’ Rationale:** Individuals with androgen insensitivity syndrome, which is classified to code 257.8, have XY chromosomes, but they develop as females with normal female genitalia and mammary glands. Testicles are present in the same general area as the ovaries, but are undescended and are at risk for development of testicular cancer, and so they are generally surgically removed. These individuals are raised as females. A similar clinical scenario can occur with certain disorders that cause a defective biosynthesis of testicular androgen. This disorder is classified to code 257.2.

**MCE Changes: Questionable Admission-Principal Diagnosis Only (70FR47312)**

Code 305.1, Tobacco use disorder, has been added to the MCE edit “Questionable Admission-Principal Diagnosis Only.”

**CMS’ Rationale:** Medicare does not cover tobacco cessation services if these services are the primary reason for the hospitalization.

**MCE Changes: Non-Covered Procedure Edit (70FR47312)**

Codes 00.61, Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s), 00.63, Percutaneous insertion of carotid artery stent(s), and V70.7, Examination of participant in clinical trial, have been removed from the MCE noncovered procedure edit.

**CMS’ Rationale:** Medicare now covers percutaneous angioplasty of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies.

**MCE Changes: Error in Non-Covered Procedure Edit (70FR47312)**

Code 36.32, Other transmyocardial revascularization, has been removed from the non-covered procedure edit.

**CMS’ Rationale:** This procedure is covered as a late or last resort for patients with severe angina, and so its inclusion in the non-covered procedure edit was an error.

**Changes to Surgical Hierarchy (70FR47312)**

A number of changes have been made to the surgical hierarchies of MDC 5 (Circulatory System and MDC 8 (Musculoskeletal System and Connective Tissue). These changes, which are the result of the 2006 DRG modifications, ensure that cases eligible for more than one surgical DRG group to the most resource-intensive DRG. The list of changes to the surgical hierarchies can be found on pages 47312 – 47313 of the final rule.
Comprehensive Review of the CC List (70FR47314)

CMS is planning a comprehensive and systematic review of the CC list for the hospital inpatient PPS rule for fiscal year 2007. As part of this process, they plan to consider revising the standard for determining when a condition is a CC. By performing a comprehensive review of the CC list, CMS expects to revise the DRG system to better reflect resource utilization and remove conditions from the CC list that only have a marginal impact on a hospital’s costs.

Until this comprehensive review and analysis have been completed, CMS will not know whether there is merit in adopting a modification of the CC list or whether it will be necessary to adopt a more comprehensive change to the DRG system such as the APR-DRGs. In addition to conducting a review of the CC list, CMS also plans to engage a contractor to study the APR-DRGs over the next year.

CMS’ Rationale: There has been no substantive review of the CC list since its original development. The vast majority of patients treated in the hospital inpatient setting have a CC as currently defined, and so it is possible that the CC distinction has lost much of its ability to differentiate patients’ resource needs.

Reassignment of Procedures among DRGs 468, 476, and 477 (70FR47317)

Code 26.12, Open biopsy of salivary gland or duct, has been moved out of DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis) and reassigned to DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis).

CMS’ Rationale: The assignment of code 26.12 to DRG 468 is believed to be an error because code 26.31, Partial sialoadenectomy, which is a more extensive procedure than code 26.12, is assigned to DRG 477.

Changes to the ICD-9-CM Coding System (70FR47317)

Several commenters recommended that CMS modify its DRG GROUPER and instruct fiscal intermediaries to expand the number of diagnoses processed from 9 to 25 and the number of procedures processed from 6 to 25. CMS noted that while the Health Insurance Portability and Accountability Act (HIPAA) regulations require CMS to accept up to 25 ICD-9-CM diagnosis and procedure codes on the electronic claim, they do not require that CMS process that many codes. However, CMS agreed that there is value in retaining additional data on patient conditions that would result from expanding Medicare’s data system so it can accommodate additional diagnosis and procedure codes. They will consider this issue further as they contemplate refinements to the DRG system to better recognize patient severity.

CMS’ Rationale: While it would be a simple matter to modify the GROUPER software to accept and evaluate 25 diagnosis and 25 procedure codes, extensive lead time to allow
for modifications to CMS’ internal and contractors’ electronic systems would be necessary before they could store and process this additional information. Therefore, they are unable to move forward with this recommendation without carefully evaluating implementation issues.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES

INFUSE® – Bone Morphogenetic Proteins (BMPs) for Spinal Fusions (70FR47344)

Add-on payments for INFUSE® bone graft for spinal fusions have been terminated.

InSync® Defibrillator System – Cardiac Resynchronization Therapy with Defibrillation (70FR47345)

Add-on payments for cardiac resynchronization therapy with defibrillation have been terminated.

Kinetra® Implantable Neurostimulator for Deep Brain Stimulation (70FR47345)

Add-on payments for the Kinetra® Implantable Neurostimulator will continue for fiscal year 2006.

Endovascular Graft Repair of the Thoracic Aorta – GORE TAG Device (70FR47356)

The GORE TAG device for endovascular graft repair of the thoracic aorta has been approved for a new technology add-on payment. New code 39.73, Endovascular implantation of graft in thoracic aorta, should be assigned for cases involving this device.

Restore® Rechargeable Implantable Neurostimulator (70FR47357)

New technology add-on payments have been approved for rechargeable, implantable neurostimulators. Cases involving these devices will be identified by the presence of new code 86.98, Insertion or replacement of dual array rechargeable neurostimulator pulse generator.
OTHER DECISIONS AND CHANGES TO THE INPATIENT PPS

Changes to DRGs Subject to the Postacute Care Transfer Policy (70FR47411)

The criteria for inclusion of a DRG in the postacute care transfer policy have been revised:
- Geometric length of stay of at least 3 days,
- At least 2,050 postacute transfer cases,
- At least 5.5% of cases are discharged to postacute care prior to geometric mean length of stay,
- If DRG is one of a paired set based on presence or absence of CC, both DRGs are included (if either one meets the other three criteria).

Under the revised criteria, 182 DRGs are now subject to the postacute care transfer policy. These DRGs are identified in Table 5 (page 47617) in the final rule.

Requirements for Hospital Reporting of Quality Data (70FR47421)

Hospitals must continuously submit the required 10 measures each quarter according to the schedule found on the Web site at: http://www.qnetexchange.org. New facilities must submit the data using the same schedule, as dictated by the quarter they begin discharging patients. To ensure the submission of reliable and valid data, CMS has added a new requirement for the data for the fiscal year 2006 payment update. Hospitals must pass CMS’ validation requirement of a minimum of eighty percent reliability, based upon CMS’ chart-audit validation process, for the third quarter data of calendar year 2004.
CMS’ RESPONSE TO AHIMA’S COMMENTS

AHIMA provided comments to CMS in response to the proposed rule regarding fiscal year 2006 changes to the Medicare inpatient hospital PPS (published in the May 4, 2005 issue of the Federal Register). CMS responded to these comments directly and indirectly in the final rule:

Strokes

AHIMA Comments: “AHIMA believes that, even given the small number of cases in the MEDPAR database, it would be reasonable to split stroke cases with and without use of a reperfusion agent into separate DRGs.”

“AHIMA shares CMS’ concern regarding the possible underreporting of ICD-9-CM code 99.10, Injection or infusion of therapeutic or prophylactic substance, because it currently does not affect DRG assignment. Our members are encouraged to report all appropriate diagnosis and procedure codes, regardless of the impact on reimbursement.”

CMS Response: CMS created a new DRG in order to distinguish cases involving the use of a thrombolytic agent. They also reiterated that all cases should be accurately and completely coded, irrespective of the DRG implications of a specific code. By coding accurately and completely, CMS will have more information on patient care costs for different services and treatments that better enable them to research further changes to the DRG system.

Automatic Implantable Cardioverter/Defibrillator

AHIMA Comments: “AHIMA supports CMS’ proposal to remove code 37.26 from the list of cardiac catheterizations for DRGs 535 and 536. Once the coding issues have been resolved and consistent data are being collected, the appropriate DRG assignment(s) for code 37.26 can be re-examined.”

“We also agree that there has been considerable confusion as to the proper use of code 37.26. In addition to confusion as to whether code 37.26 should be reported when an electrophysiologic study (EPS) is performed as part of a defibrillator implantation, there has also been confusion as to whether this code should be reported for defibrillator device checks.”

CMS’ Response: CMS removed code 37.26 from the list of cardiac catheterizations for DRGs 535 and 536. They also stated that they would address issues with the use of code 37.26 at the next ICD-9-CM Coordination and Maintenance Committee meeting.

Coronary Artery Stents

AHIMA Comments: “We support CMS’ proposal to restructure the coronary stent DRGs such that the cases are split on the basis of the presence or absence of a CC. We agree
that these DRGs shouldn’t be restructured to account for multiple stent insertion until sufficient data has been collected using the new ICD-9-CM procedure codes that will go into effect this October. We also concur with CMS’ recommendation that coders should code as accurately as possible, assigning as many codes as necessary to describe each case.”

**CMS’ Response:** New DRGs for percutaneous insertion of vascular stents have been created, and the new DRG pairs are split on the basis of the presence or absence of a major cardiovascular condition. Coders are encouraged to record codes accurately, irrespective of whether the code has an impact on the DRG assignment, as these data will potentially be the basis for future DRG restructuring.

**Multiple Level Spinal Fusion**

**AHIMA Comments:** “For the proposed new DRG for non-cervical spinal fusions with a principal diagnosis of curvature of the spine or malignancy, codes 737.40-737.43 are included in the list of applicable principal diagnoses. However, these codes are manifestation codes, and, according to ICD-9-CM conventions, can never be sequenced as the principal diagnosis. The underlying etiology would be sequenced as the principal diagnosis. Therefore, these codes should not be included in the list of principal diagnoses for proposed DRG 546.”

**CMS’ Response:** CMS agreed that some of the codes included in the list of applicable principal diagnoses cannot be reported as a principal diagnosis because they are manifestation codes. These codes have been removed from the list of principal diagnoses. They will lead to assignment of the new spinal fusion DRG when they are reported as secondary diagnoses.

**Newborn Age Edit**

**AHIMA Comments:** “While we agree that comprehensive edits for pediatric admissions are more appropriately developed outside of the Medicare program, nevertheless, there is a newborn age edit in the MCE. As long as this edit exists, it should be accurate, up-to-date, and not include codes that could appropriately be assigned to older children and adults. If there are errors in this edit, an adult Medicare claim could be rejected due to inappropriate triggering of the newborn age edit. The introduction for Chapter 15 in ICD-9-CM states that this chapter includes conditions, which have their origin in the perinatal period even though death or morbidity occurs later. Some of the conditions included in this chapter may potentially persist into adulthood. CMS should utilize the necessary expertise to develop and maintain pediatric edits on an up-to-date basis, or consider deleting this edit from the MCE.”

**CMS’ Response:** The recommendation to remove the newborn and pediatric edits from the MCE has merits and will be considered for fiscal year 2007. However, it is important that CMS have an opportunity to analyze the issue further and consider any comments from interested parties before eliminating these edits.
Comprehensive Review of CC List

**AHIMA Comments:** “As part of CMS’ efforts to improve the DRG system to better recognize severity, we recommend that CMS seriously consider adoption of a refined DRG system that accounts for variations in severity of illness, and, as noted above, also consider changing its system and requirement to allow providers to submit all appropriate diagnoses and procedures associated with the claim.”

**CMS’ Response:** Until the comprehensive review and analysis of the CC list are complete, CMS will not know whether there is merit in adopting a modification of the CC list or whether it will be necessary to adopt a more comprehensive change in the DRG system, such as APR-DRGs.

Changes to DRGs Subject to the Postacute Care Transfer Policy

**AHIMA Comments:** “AHIMA opposes CMS’ proposal to significantly expand the list of DRGs subject to the postacute transfer policy. In order to identify patients meeting the home health criteria, hospitals must often contact patients to determine if they have received home health services within three days after discharge. This is an extremely labor-intensive process, delays claims submission, and an incorrect discharge status code may still end up being reported if hospital personnel are unable to reach the patient to determine whether the home health criteria have been met. A major expansion in the number of DRGs included in this policy, without any changes to the home health criteria, will place a tremendous administrative burden on hospitals because of the increased number of patients subject to this cumbersome process.”

**CMS’ Response:** The criteria for inclusion of DRGs in the postacute care transfer policy were revised, resulting in a significant expansion in the number of qualifying DRGs.

Use of All Reported Diagnosis and Procedure Codes

**AHIMA Comments:** “AHIMA recommends that CMS use all reported diagnoses and procedures, not just the first nine diagnoses and six procedures, in their DRG analysis and DRG classification process. With more care being provided on an outpatient basis, hospital inpatients tend to be sicker than in the past. There has also been an increasing demand for greater coding specificity. Both of these trends mean higher numbers of reportable diagnoses and procedures for many hospital inpatient cases.”

**CMS’ Response:** CMS acknowledged the value in retaining additional data and agreed to consider this issue further as they contemplate refinements to the DRG system to better recognize patient severity.
Resources

The final rule regarding the fiscal year 2006 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 12, 2005 issue of the Federal Register located at: http://www.access.gpo.gov/su_docs/fedreg/a050812c.html.

AHIMA’s letter to CMS regarding the proposed rule for fiscal year 2006 revisions to the Medicare hospital inpatient prospective payment system can be found on the Policy and Government Relations section of the AHIMA web site: http://www.ahima.org/dc/.