

FY 2003 Changes to the Medicare DRG Classifications and ICD-9-CM codes

The FY 2003 regulations for the Acute Care Hospital Inpatient Prospective Payment System have been finalized by the Centers for Medicare and Medicaid Services (CMS). These regulations are effective October 1, 2002. The changes to the DRG Classification System and ICD-9-CM codes are extensive this year. These changes include:

MDC 1 Diseases and Disorders of the Nervous System

Revision of:

DRG 1 Craniotomy age > 17 Except for Trauma (FY 2002 relative weight (3.2713)

DRG 2 Craniotomy for Trauma age > 17 (FY 2002 relative weight 3.3874)

to:

DRG 1 Craniotomy w CC (relative weight 3.7399)

DRG 2 Craniotomy w/o CC (relative weight 1.9730)

This revision has been made due to the creation of MDC 24 Multiple Trauma. CMS statistics show that trauma patients with craniotomy also generally have other multiple injuries resulting in assignment of a Multiple Trauma DRG in MDC 24 rather than DRG 2. Analysis also showed that there is a significant difference in the cost of providing services in DRG 1 based on the presence or absence of a "CC" diagnosis. Therefore, DRG 1 and 2 have been re-designated as a pair of "CC" and "no CC" DRGs.

Revision of:

DRG 14 Specific Cerebrovasc. Disorders Except TIA (FY 2002 relative weight 1.1655)

DRG 15 TIA & Precerebral Occlusion (FY 2002 0.7349)

to:

DRG 14 Intracranial Hemorrhage and Stroke with Infarction (relative weight 1.2943)

DRG 15 Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction (relative weight 0.9858)

New DRG 524 Transient Ischemia (relative weight (0.7238)

DRG 14 will include a revised list of PDX codes:

430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0	Nontraumatic extradural hemorrhage
432.1	Subdural hemorrhage
432.9	Unspecified intracranial hemorrhage
433.01	Occlusion and stenosis of carotid artery with cerebral infarction
433.11	Occlusion and stenosis of carotid artery with cerebral infarction
433.21	Occlusion and stenosis of vertebral artery with cerebral infarction

433.31	Occlusion and stenosis of multiple and bilateral arteries with cerebral infarction
434.01	Cerebral thrombosis with cerebral infarction
434.11	Cerebral embolism with cerebral infarction
434.91	Cerebral artery occlusion, unspecified with cerebral infarction

DRG 15 will include the following revised list of PDX codes:

433.00	Occlusion and stenosis of basilar artery without mention of cerebral infarction
433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction
433.20	Occlusion and stenosis of vertebral artery without mention of cerebral infarction
433.30	Occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction
433.80	Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction
433.90	Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction
434.00	Cerebral thrombosis without mention of cerebral infarction
434.10	Cerebral embolism without mention of cerebral infarction
434.90	Cerebral artery occlusion, unspecified, without mention of cerebral infarction
436	Acute, but ill-defined, cerebrovascular disease

The newly created DRG 524, Transient Ischemia, will include PDX codes:

435.0	Basilar artery syndrome
435.1	Vertebral artery syndrome
435.2	Subclavian steal syndrome
435.3	Vertebrobasilar artery syndrome
435.8	Other specified transient cerebral ischemias
435.9	Unspecified transient cerebral ischemia
437.1	Other generalized ischemic cerebrovascular disease

Two codes formerly assigned to DRG 14 have been moved to DRGs 34 and 35, Other Disorders of the Nervous System w or w/o CC. They are:

437.3	Nonruptured cerebral aneurysm
784.3	Aphasia

The changes to DRGs 14, 15, 34, 35 and the addition of DRG 524 have been made to better categorize patients with severe intracranial lesions or subarachnoid hemorrhage with severe consequences versus patients with TIA or patients who suffered strokes with

minor consequences as well as those having occluded vessels without having a full-blown stroke.

MDC 5 Circulatory System

Three new DRGs have been created:

DRG 525 Heart Assist System Implant (relative weight 11.6479)

Cases will assign to DRG 525 if there is a principal diagnosis from MDC 5 and one of the following procedures:

- 37.62 Implant of other heart assist system
- 37.63 Replacement and repair of heart assist system
- 37.65 Implant of an external, pulsatile heart assist system
- 37.66 Implant of an implantable, pulsatile heart assist system

These procedures previously were assigned to DRGs 104 and 105 Cardiac Valve and Other Major Cardiothoracic Procedures w and w/o Cardiac Cath (FY 2002 relative weights 7.8411 and 5.6796).

The reason this new DRG was created was that the cost of care for these procedures significantly exceeded other procedures assigned to DRGs 104 and 105.

The second and third new DRGs in MDC 5 are:

DRG 526 Percutaneous Cardiovascular Procedure with Drug Eluting Stent with AMI (relative weight 3.1176)

DRG 527 Percutaneous Cardiovascular Procedure with Drug Eluting Stent w/o AMI (relative weight 2.5342)

DRG 526 requires one of the following principal diagnoses:

- 410.01 AMI, anterolateral wall, initial episode of care
- 410.11 AMI, other anterior wall, initial episode of care
- 410.21 AMI, inferolateral wall, initial episode of care
- 410.31 AMI, inferoposterior wall, initial episode of care
- 410.41 AMI, inferior wall, initial episode of care
- 410.51 AMI, other lateral wall, initial episode of care
- 410.61 True posterior wall infarction, initial episode of care
- 410.71 Subendocardial infarction, initial episode of care
- 410.81 AMI, of other specified sites, initial episode of care
- 410.91 AMI, unspecified site, initial episode of care

DRG 526 and DRG 527 require one of the following operating room procedures:

- 35.96 Percutaneous valvuloplasty
- 36.01 Single vessel PTCA or coronary atherectomy w/o mention of thrombolytic agent

- 36.02 Single vessel PTCA or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent
- 36.05 Multiple vessel PTCA or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent
- 37.34 Catheter ablation of lesion or tissues of heart

or nonoperating room procedures:

- 37.26 Cardiac electrophysiologic stimulation and recording studies
- 37.27 Cardiac mapping

And nonoperating room procedure:

- 36.07 Insertion of drug-eluting coronary artery stent(s)

Diagnosis code 398.91 Rheumatic Heart Failure has been moved from DRG 125 Circulatory Disorders Except AMI w Cardiac Cath w/o Complex Diagnosis to DRG 124 Circulatory Disorders Except AMI w Cardiac Cath with Complex Diagnosis.

Procedure code 92.27 Implantation or insertion of radioactive elements has previously been assigned to either DRG 517 Percutaneous Cardiovascular Procedures without Acute Myocardial Infarction with Coronary Artery Stent Implant (FY 2002 relative weight 2.1379) or DRG 468 Extensive OR Procedure Unrelated to Principal Diagnosis (FY 2002 relative weight 3.8756).

With FY 2003 changes, code 92.27 has been assigned to DRG 120 (relative weight 2.2383) in those instances where there is no percutaneous cardiovascular procedure.

MDC 10 Endocrine, Nutritional, and Metabolic Diseases and Disorders

Several changes have been made related to the DRG assignment for cystic fibrosis codes:

DRGs 79/80/81 Respiratory Infection and Inflammations

277.02 (new code) Cystic fibrosis with pulmonary manifestations

DRG 188/189/190 Other Digestive System Diagnoses

277.03 (new code) Cystic fibrosis with gastrointestinal manifestations

DRGs 296/297/298 Nutritional & Metabolic Disease

277.09 (new code) Cystic fibrosis with other manifestations

The reason these new codes were created and assigned to the above DRGs was to better classify resource consumption of cystic fibrosis patients with various manifestations.

MDC 11 Diseases and Disorders of the Kidney and Urinary Tract

Code 86.07 Insertion of totally implantable vascular access device (VAD) has been designated as an O.R. procedure under MDC 11, Diseases and Disorders of the Kidney and Urinary Tract.

It is assigned to DRG 315 Other Kidney and Urinary Tract O.R. Procedures (relative weight 2.1046) when combined with one of the following principal diagnosis codes from DRG 316:

403.01	Malignant hypertensive renal disease with renal failure
403.11	Benign hypertensive renal disease with renal failure
403.91	Unspecified hypertensive renal disease with renal failure
404.02	Malignant hypertensive heart and renal disease with renal failure
404.12	Malignant hypertensive heart and renal disease with renal failure
404.92	Unspecified hypertensive heart and renal disease with renal failure
584.5	Acute renal failure with lesion of tubular necrosis
584.6	Acute renal failure with lesion of renal cortical necrosis
584.7	Acute renal failure with lesion of renal medullary (papillary) necrosis
584.8	Acute renal failure with other specified pathological lesion in kidney
584.9	Acute renal failure, unspecified
585	Chronic renal failure
586	Renal failure, unspecified
788.5	Oliguria and anuria
958.5	Traumatic anuria

The reason for this change is to better reimburse hospitals for patients with kidney disease who have a VAD implanted.

Code 57.87 Reconstruction of urinary bladder has been reassigned from DRGs 308 and 309 Minor Bladder Procedures w and w/o CC (relative weights 1.6387 and 0.8959) to DRGs 303, 304 and 305 Major Bladder Procedures (relative weights 2.4282, 2.3343 and 1.2016) to recognize the cost of providing a bladder reconstruction.

MDC 15 Newborns and Other Neonates with Conditions Originating in the Perinatal Period

New ICD-9-CM codes 747.83 through 779.89 have been created to differentiate between extreme immaturity or gestational age, or both. These codes and their respective DRG assignments are included in the Federal Register Final Rules Table 6A.

MDC 23 Factors Influencing Health Status and Other Contacts with Health Services

Code V10.53 History of malignancy, renal pelvis has been assigned to DRG 465 Aftercare with History of Malignancy as Secondary Diagnosis (relative weight 0.6786).

Pre-MDCs

A major change has been made to DRG 482 Tracheostomy for Face, Mouth, and Neck Diagnoses (relative weight 3.5614) and DRG 483 Tracheostomy except for Face, Mouth and Neck Diagnoses (relative weight 17.0510).

DRG 483 has been retitled to Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck.

Procedure code 96.72 Mechanical Ventilation greater than 96 hours has been assigned to DRG 483.

The following types of cases will assign to DRG 482:

Tracheostomy for face, mouth, and neck diagnoses without procedure code 96.72.

The following types of cases will assign to DRG 483:

Tracheostomy except for face, mouth, and neck Diagnoses regardless of the assignment of 96.72

Tracheostomy for face, mouth, and neck diagnoses with procedure code 96.72.

The reason for this change is to recognize the cost of those tracheostomy cases for face, mouth and neck diagnoses that receive mechanical ventilation for an extended period of time.

Other Changes

Diagnosis code 436 CVA, has been removed from the Medicare Code Editor list of “nonspecific principal diagnoses).

Surgical Hierarchy

The only change to the DRG Surgical Hierarchy by MDC occurs in MDC 5 Circulatory System. The revised hierarchy is as follows:

DRG 116
DRG 526
DRG 516
DRG 527
DRG 517
DRG 518

All other DRGs in MDC 5 remain in the same surgical hierarchy order. Each year a number of operative procedure codes are removed from DRG 468 Major Operative Procedure Unrelated to Principal Diagnosis and placed in either DRG 476

Prostatic OR Procedure Unrelated to Principal Diagnosis or DRG 477 Non-Extensive OR Procedure Unrelated to Principal Diagnosis. A listing of those procedures can be found in the Federal Register Final Rules pages 49999-50000.

There are also a number of ICD-9-CM code additions/deletions/revisions not discussed in this article. They can also be found in Table 6A of the Federal Register Final Rules.

The Final Rules in their entirety can be accessed at www.access.gpo.gov/su_docs/fedreg/a020801c.html

SUMMARY

As described above, FY 2003 changes to the Inpatient Prospective Payment System DRG Classification and ICD-9-CM Code Classification are the most extensive seen in a number of years. There are significant financial implications for hospitals especially in the revisions to DRGs 14, 15, 34, 35, 525, 526 and 527, 315, and 482 and 483.

It is suggested that the hospital model these changes to quantify the financial impact they should expect to see in FY 2003. In order to accurately model these changes, assistance will be required from the health information management coding experts on staff at the hospital because queries will need to be written that include specific ICD-9-CM diagnosis and/or procedure codes related to each DRG.

Also, with regards to the changes in DRG 482, it is recommended that special attention be given to sequencing code 96.72 among the top 6 procedure codes when it is assigned. Otherwise the case will assign to DRG 482 rather than the correct assignment, DRG 483.

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