# 2002 DRG Updates Already in Effect



*by Mary Uppena, RHIA, CPHQ*

The 2002 diagnosis related group (DRG) updates went into effect October 1, 2001. With the implementation of these changes to the hospital inpatient DRGs portion of the prospective payment system (PPS), there will be 499 DRGs in 25 Major Diagnostic Categories (MDCs).

**Changes to Pre-MDCs**

Two new DRGs have been created for the special instances of Simultaneous Pancreas/Kidney Transplant (DRG 512) and Pancreas Transplant (DRG 513). Cases grouped in either of these DRGs must have as either a principal or secondary diagnosis one of the following listed codes plus one or more of the procedure codes 52.80, 52.82, or 55.69.

Diagnosis codes required for DRGs 512 and 513 include: 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 585, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, V42.0, and V43.89.

The logic for DRGs 512 and 513 accepts the pair of diagnosis codes in any position (principal/secondary or secondary/secondary). For DRG 512, a pair of procedure codes (52.80 and 55.69 or 52.82 and 55.69) must be present along with the two diagnosis codes. For DRG 513, only one procedure code must be used along with the two diagnosis codes.

If a patient undergoes both an intestinal transplant and a pancreas transplant, the case will group to the new DRG 513 Pancreas Transplant. CMS (the Centers for Medicare and Medicaid Services, formerly HCFA) is also adding intestines and multivisceral organs to the list of organs for which Medicare pays the acquisition costs, to be paid on a reasonable cost basis.

## Changes to MCD 3 Diseases and Disorders of the Ear, Nose, Mouth and Throat

Diagnosis code 525.12 Loss of teeth due to periodontal disease is now listed within DRGs 185 Dental and Oral Diseases Except Extractions and Restorations, Age Greater than 17, 186 Dental and Oral Diseases Except Extractions and Restorations, Age 0-17, and 187 Dental Extractions and Restorations.

## Changes to MDC 5 Diseases and Disorders of the Circulatory System

Insertion of cardiac defibrillators (procedure codes 37.94 through 37.98) had been included in DRGs 104 and 105, the DRGs for cardiac valve procedures. They will now have their own DRGs: 514 Cardiac Defibrillator Implant with Cardiac Catheterization and 515 Cardiac Defibrillator Implant without Cardiac Catheterization. DRG 514 also must contain one of the following cardiac catheter codes: 37.21, 37.22, 37.23, 37.26, 88.52, 88.53, 88.54, 88.55, 88.56, 88.57, or 88.58.

PTCA procedures (procedure codes 35.96, 36.01, 36.02, 36.05, 36.09, 37.34, 92.27, 36.06, 37.26, and 37.27) have been taken out of their present DRGs and relocated to three new DRGs. DRG 116 Other Permanent Cardiac Pacemaker implant or PTCA with Coronary Artery Stent Implant was re-titled "Other Cardiac Pacemaker Implantation," and will contain only pacemaker procedures. DRG 112 Percutaneous Cardiovascular Procedures will no longer exist. The three new DRGs include:

- DRG 516 Percutaneous Cardiovascular Procedures with Acute Myocardial Infarction (AMI)
- DRG 517 Percutaneous Cardiovascular Procedures without AMI
- DRG 518 Percutaneous Cardiovascular Procedures without AMI, without Coronary Artery Stent Implant

A procedure code already exists for Removal of heart assist system (37.64). However, there was no distinction made between removals performed as invasive (OR) and non-invasive (bedside) procedures. A new procedure code was created, 97.44

Nonoperative removal of heart assist system to make this distinction. This new code will not be considered a procedure code effecting DRG assignment.

## Changes to MDC 8 Diseases and Disorders of the Musculoskeletal System and Connective Tissue

Previously, all spinal refusion procedures were coded 81.09, regardless of location or technique. If a patient underwent refusion of more than one vertebrae, it should have been paid under DRG 496 Combined Anterior/Posterior Spinal Fusion; however, 81.09 was not a procedure code included in that DRG. The following new spinal refusion codes were created:

- 81.30 Refusion of spine, NOS
- 81.31 Refusion of atlas-axis spine
- 81.32 Refusion of other cervical spine, anterior technique
- 81.33 Refusion of other cervical spine, posterior technique
- 81.34 Refusion of dorsal and dorsolumbar spine, anterior technique
- 81.35 Refusion of dorsal and dorsolumbar spine, posterior technique
- 81.36 Refusion of lumbar and lumbosacral spine, anterior technique
- 81.37 Refusion of lumbar and lumbosacral spine, lateral transverse process technique
- 81.38 Refusion of lumbar and lumbosacral spine, posterior technique
- 81.39 Refusion of spine, NEC

These new codes were added, as appropriate, to existing DRGs 496, 497, and 498.

Approaches for all spinal fusion and refusion procedures were then changed to reflect the less invasive nature of performing an anterior or posterior cervical fusion or refusion in comparison to approaches for other levels of the spine. Procedure codes 81.02, 81.03, 81.32, and 81.33 were then removed from DRGs 497 and 498. Two new DRGs were created for these cases:

- DRG 519 Cervical Spinal Fusion with CC
- DRG 520 Cervical Spinal Fusion without CC

The relative weights for DRGs 497 and 498 were then raised to reflect the more complex procedures remaining in these DRGs. These two DRGs were re-titled "Spinal Fusion Except Cervical with CC" (497) and "Spinal Fusion Except Cervical without CC" (498). Comments made by the manufacturers of spinal fusion devices for additional separation of these cases will be discussed as possible changes for 2003.

It was also important to designate which spinal fusion and refusion procedures were considered anterior or posterior approaches. Anterior approach codes were listed as 81.02, 81.04, 81.06, 81.32, 81.34, and 81.36. Posterior approach codes were listed as 81.03, 81.05, 81.07, 81.08, 81.33, 81.35, and 81.38.

The State of California Division of Worker's Compensation commented that "recent increased use of the new implantation devices, hardware, and instrumentation, coupled with requirements for intensive hospital services accompanying use of new procedures, has led to inadequate reimbursement in these DRGs" (497 and 498). They requested that CMS examine these DRGs for any potential problems with Medicare reimbursement. CMS commented that the present ICD-9-CM procedure codes did not provide enough specification to verify this and suggested a more comprehensive procedure coding system, such as ICD-10-PCS, would allow them to capture enough detail to make this type of a determination.

## Changes to MDC 15 Newborns and Other Neonates With Conditions Originating in the Perinatal Period

Two diagnosis codes were removed from DRG 389 Full Term Neonate with Major Problems (773.0 Hemolytic disease due to Rh isoimmunization and 773.1 Hemolytic Disease Due to ABO isoimmunization) and 17 diagnosis codes were added to DRG 391 Normal Newborn.

The diagnosis code 779.3, Feeding problems in newborns, will be moved from DRG 391 Normal Newborn and is reassigned to DRG 390 Neonate with Other Significant Problems. In addition, codes 773.0 and 773.1, Hemolytic disease codes as listed above, were removed from DRG 389 and DRG 387. They were reassigned to DRG 390 Neonate with Other Significant Problems.

The following list of codes are no longer grouped into DRG 390 Neonate with Other Significant Problems when they are reported as secondary diagnosis codes:

- 478.1 Other diseases of nasal cavity and sinuses
- 520.6 Disturbances in tooth eruption
- 623.8 Other specified noninflammatory disorders of vagina
- 709.00 Dyschromia, unspecified
- 709.01 Vitiligo
- 709.09 Dyschromia, other
- 744.1 Accessory auricle
- 754.61 Congenital pes planus
- 757.33 Congenital pigmentary anomalies of skin
- 757.39 Other specified anomaly of skin
- 764.08 "Light for dates" without mention of fetal malnutrition, 2,000-2499 grams
- 764.98 Fetal growth retardation, unspecified, 2000-2499 grams
- 772.6 Cutaneous hemorrhage
- 794.15 Abnormal and auditory function studies
- 796.4 Other abnormal clinical findings
- V20.2 Routine infant or child health check
- V72.1 Examination of ears and hearing

These diagnosis codes now group into DRG 391, Normal Newborn.

It was noted that code 770.7 Chronic respiratory disease rising in the perinatal period may be assigned for a patient of any age. The Medicare Code Editor was causing these claims to be rejected. This issue has been resolved by removing the code 770.7 from DRG 387 Prematurity with Major Problems, and DRG 389 Full Term Neonate with Major Problems. This code has now been added to DRG 92 Interstitial Lung Disease with CC, and DRG 93 Interstitial Lung Disease without CC.

## Changes to MDC 20 Alcohol/Drug Use and Alcohol/Drug-Induced Organic Mental Disorders

MDC 20 has been totally redesigned for 2002. The decision hierarchy first asks if the patient left against medical advice (AMA). These cases are assigned to the newly redesigned DRG 433 Alcohol/Drug Abuse or Dependence, Left Against Medical Advice. The remainder of the existing DRGs within MDC 20 will no longer be valid (DRGs 434 through 438). The next question in the new hierarchy is the identification of a complication or comorbidity for the case. If a CC is identified, the case is grouped to new DRG 521 Alcohol/Drug Abuse of Dependence with CC. The remaining cases are divided between new DRG 522 Alcohol/Drug Abuse of Dependence without CC, with Rehabilitation Therapy, and new DRG 523 Alcohol/Drug Abuse or Dependence without CC, without Rehabilitation Therapy. Procedure codes allowed in DRG 522 include 94.61, 94.63, 94.64, 94.66, 94.67, and 94.69.

## Changes to MDC 25 Human Immunodeficiency Virus Infections

In the 2000 changes, the following new diagnosis codes were created:

- 783.21 Loss of weight
- 783.22 Underweight
- 783.40 Unspecified lack of normal physiological development
- 783.41 Failure to thrive
- 783.42 Delayed milestones
- 783.43 Short stature

These codes were inadvertently left out of MDC 25 and are now included for HIV patients as related conditions.

**Changes to Surgical Hierarchies**

As part of the annual DRG update process, CMS goes through all of the surgical DRGs to examine their hierarchy. That is, if an inpatient was eligible for more than one surgical DRG, would they be grouped to the most resource-intensive one? This is a major comparison of all surgical DRGs across the board.

In the pre-MDCs, changes will be made to re-align DRG 495 Lung Transplant above DRG 481 Bone Marrow Transplant. New DRGs 512 Simultaneous Pancreas/Kidney Transplant and 513 Pancreas Transplant are now above DRG 495 Lung Transplant.

In MDC 5 Diseases and Disorders of the Circulatory System, the new DRGs 514 and 515 are ordered above DRG 108 Other Cardiothoracic Procedures. The new DRGs 516, 517, and 518 are ordered above DRGs 478 and 479 Other Vascular Procedures.

In MDC 8 Diseases and Disorders of the Musculoskeletal System and Connective Tissue, the new DRGs 519 and 520 are ordered above DRGs 499 and 500 Back and Neck Procedures Except Spinal Fusion.

In MDC 20 Alcohol/Drug Use and Alcohol/Drug-Induced Organic Mental Disorders, the order will be as follows:

- DRG 433 Alcohol/Drug Abuse or Dependence, Left AMA
- DRG 521 Alcohol/Drug Abuse or Dependence With CC
- DRG 522 Alcohol/Drug Abuse or Dependence With Rehabilitation Therapy Without CC
- DRG 523 Alcohol/Drug Abuse or Dependence Without Rehabilitation Therapy Without CC

## Proposed change to MDC 11 Diseases and Disorders of the Kidney and Urinary Tract

This proposal was inadvertently left out of the May 4, 2001, *Federal Register* proposed DRG changes, so at this time, it is only a proposed change and may be implemented in 2003. Procedure code 86.07 Insertion of totally implantable vascular access device is currently not a code affecting DRG assignment. It is proposed to be included in DRG 315 Other Kidney and Urinary Tract OR Procedures.

CMS cautioned hospitals against the practice of assigning 86.07 to designate insertion of the Lifesite brand hemodialysis access product. Apparently, the brochure accompanying this device states procedure code 86.07 should be used. The official DRG Grouper will group this to the medical DRG 316 Renal Failure. The use of procedure code 39.93 Insertion of vessel-to-vessel canula will force cases into the surgical DRG 315, but investigation of these cases by CMS has not found that the actual 39.93 procedure was performed. Again, CMS cautions hospitals to only submit codes for procedures performed.

### Changes to the Complications and Comorbidities Exclusions List

The official changes to this list included new codes and deleted codes.

## Clinical Trials

CMS had implemented a policy of paying for inpatient hospital stays for Medicare beneficiaries participating in clinical trials. They had directed that the codes V70.7 Examination for normal comparison or control in clinical research or V70.5 Health examination of defined subpopulations be used to indicate these patients. This created some confusion because of the unclear definitions of these codes. As a result, the description of code V70.7 is now changed to "Examination of patient in clinical trial."

Add-on Payments for Acquired Hemophilia Diagnoses

The diagnosis codes 286.5 and 286.7 now qualify for an additional payment for costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients.

Movement of Procedure Codes from DRG 468

### References

- The fiscal year 2002 inpatient PPS changes can be found in the August 1, 2001, *Federal Register* at www.access.gpo.gov/su_docs/fedreg/a010801c.html.
- For more information on PPS, visit the Center for Medicare and Medicaid Services Web site at www.hcfa.gov.

***Mary Uppena*** *(*mary.uppena@ahima.org*) is an AHIMA coding practice manager.*

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