DRG Changes for FY 2006

by Renee Leary, MPH, and Cheryl D'Amato, RHIT, CCS

The final Medicare DRG changes for fiscal year (FY) 2006, which were published in the August 12, 2005, Federal Register, include 16 new DRGs, the deletion of 10 existing DRGs, and numerous changes to DRG assignments of current diagnosis and procedure codes. These DRG changes, along with other payment and policy changes, are expected to increase Medicare payments for hospital services by an average of 3.5 percent for urban hospitals and 3.3 percent for rural hospitals.

Pre-MDC Changes

Patients who have both an implantation and explantation of an external ventricular assist device (VAD) during the same hospital stay were added to DRG 103, Heart Transplant or Implant of Heart Assist System. These patients were found to have medical costs and lengths of stay comparable to patients with heart transplants or implantable heart-assist devices. Implantation of a VAD is represented by code 37.65 and explantation by code 37.64. Both codes must be present to be assigned to DRG 103. The Centers for Medicare and Medicaid Services (CMS) intend to have all cases assigned to DRG 103 reviewed by quality improvement organizations under the 8th Scope of Work. This review will determine if the services provided are reasonable and necessary.

Code 39.65, Extracorporeal membrane oxygenation (ECMO), was moved from DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization; without Cardiac Catheterization) to pre-MDC DRG 541. In recognition of this change, DRG 541 was retitled "ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck with Major OR."

Changes for MDC 1

CMS re-examined stroke cases assigned to DRG 14 (Intracranial Hemorrhage or Cerebral Infarction) and DRG 15 (Nonspecific CVA and Precerebral Occlusion without Infarction) and concluded that embolic stroke cases combined with tPA treatment are more expensive than other stroke cases. These patients require increased ICU monitoring and diagnostic imaging and higher pharmaceutical and laboratory costs. As a result, new DRG 559 (Acute Ischemic Stroke with Use of Thrombolytic Agent) was created, which includes all patients with nonoperating room procedure code 99.10, Injection or infusion of thrombolytic agent, and one of the principal diagnosis codes:

- 433.01, Occlusion and stenosis of basilar 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
- 433.81, Occlusion and stenosis of other specified precerebral artery, with cerebral infarction
- 433.91, Occlusion and stenosis of unspecified precerebral artery, 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

Changes to MDC 5

Significant revisions were made to a number of cardiovascular DRGs to better adjust for patient severity and to more accurately reflect differences in resource use. Within MDC 5, nine DRGs were deleted and replaced with 12 new DRGs, as shown in the table "MDC 5, Cardiovascular DRG Changes." These new DRGs differentiate patients with greater resource consumption by checking for the presence of "major cardiovascular conditions" (MCVs). (The 111 diagnosis codes recognized as MCVs are listed on pages 47477–47478 of the August 12 final rule.)

Additional changes to MDC 5 include the removal of procedure code 37.26, Cardiac electrophysiologic stimulation and recording studies (EPS), from the list of cardiac catheterizations for DRGs 535 and 536 (Cardiac Defibrillator Implant with Cardiac Catheterization). If a defibrillator is implanted and an EPS is performed with no other type of cardiac catheterization, the case will now be assigned to DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization). In addition, procedure code 35.52, Repair of atrial septal defect with prosthesis, closed technique, was moved from DRG 108 (Other Cardiothoracic Procedures) to DRG 518 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent or Acute Myocardial Infarction).

Changes to MDC 8

DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) was deleted and replaced by two DRGs: 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement). These two new DRGs better differentiate the services provided for total hip and knee replacements versus the more resource-intensive revisions of hip and knee replacements. (A list of the procedures assigned to each of these new DRGs can be found on page 47305 of the final rule.)

DRG 546, Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy, was created for noncervical spinal fusions with a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of malignancy. These cases were previously assigned to DRGs 497 and 498 (Spinal Fusion Except Cervical with CC; without CC).

Changes to Surgical Hierarchy

A number of changes were made to the surgical hierarchies of MDC 5 (Circulatory System) and MDC 8 (Musculoskeletal System and Connective Tissue). These changes are the result of the DRG additions and deletions previously described and 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.)

Procedures Unrelated to the Principal Diagnosis

Every year CMS reviews cases assigned to the unrelated procedure DRGs: 468 (Extensive OR Procedure Unrelated to Principal Diagnosis); 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis); and 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis). For FY 2006, procedure code 26.12, Open biopsy of salivary gland or duct, was moved from DRG 468 and moved to DRG 477.

Postacute Care Transfer Policy

CMS made a number of payment and policy changes for October 2006. One DRG-related change has to do with an expansion of the postacute care transfer policy. CMS pays as transfers cases in specific DRGs which are discharged to a skilled nursing facility, home health agency, or prospective payment system-exempt facility. The primary intent of this policy is to adjust hospital payments to reflect the reduced lengths of stay arising from the shift of patient care from the acute setting to the postacute setting. For FY 2006, 182 DRGs are subject to the postacute transfer policy compared to 31 DRGs in FY 2005. (The postacute transfer DRGs are identified in table 5 on pages 47617–47632 of the final rule.)

CCs and Severity of Illness

For FY 2006, limited changes were made to the standard list of complications and comorbidities (CCs) and to the CC Exclusion List. These changes were made to accommodate FY 2006 ICD-9-CM coding changes. (CC exclusion changes are included on pages 47640–47657 of the final rule.)

For FY 2007, CMS plans to perform a comprehensive and systematic review of the CC list and methodology. CMS believes that CCs, as currently defined, have lost much of their ability to differentiate patient resource needs. In addition CMS is planning to study DRG refinements that would more fully capture differences in severity of illness among patients. Alternate grouping methodologies, such as the All-Patient Refined DRGs, will be studied.

MDC 5, Cardiovascular DRG Changes			
Current Version 22		**New Version 23 DRG Modifications**	
DRG	Description	DRG	Description
107	Coronary Bypass with Cardiac Cath	547 548	Coronary Bypass with Cardiac Cath with Major CV Dx Coronary Bypass with Cardiac Cath w/o Major CV Dx
109	Coronary Bypass w/o Cardiac Cath	549 550	Coronary Bypass w/o Cardiac Cath with Major CV Dx Coronary Bypass w/o Cardiac Cath w/o Major CV Dx
115	Prm Card Pacem Impl with AMI/Hr/Shock or AICD Lead or Gnrtr	551	Permanent Cardiac Pacemaker Impl with Maj CV Dx or AICD Lead or Gnrtr
116	Other Permanent Cardiac Pacemaker Implant	552	Other Permanent Cardiac Pacemaker Implant w/o Major CV Dx
478	Other Vascular Procedures with CC	553 554	Other Vascular Procedures with CC with Major CV Dx Other Vascular Procedures with CC w/o Major CV Dx
516	Percutaneous Cardiovasc Proc with AMI	555	Percutaneous Cardiovascular Proc with Major CV Dx
517	Perc Cardio Proc with Non-Drug-eluting Stent w/o AMI	556	Percutaneous Cardiovasc Proc with Non-Drug-eluting Stent w/o Maj CV Dx
526	Percutaneous Cardio Vascular Proc with Drug-eluting Stent with AMI	557	Percutaneous Cardiovascular Proc with Drug-eluting Stent with Major CV Dx
527	Percutaneous Cardiovascular Proc with Drug-eluting Stent w/o AMI	558	Percutaneous Cardiovascular Proc with Drug-eluting Stent w/o Maj CV Dx

Reference

"Medicare Program; Changes to the Hospital Impatient Prospective Payment System and Fiscal Year 2006 Rates." *Federal Register* 70, no. 155 (2005). Available online at www.cms.hhs.gov/providerupdate/regs/cms1500f.pdf

Renee Leary *(rlear@hss-info.com) is president and COO and* ***Cheryl D'Amato*** *(cdama@hss-info.com) is director of HIM at HSS in Hamden, CT.*

Article citation:
Leary, Renne, and Cheryl D'Amato. "DRG Changes for FY 2006." *Journal of AHIMA* 76, no.10 (November/December 2005): 66-68.