A Dirge for Medicare's New DRGs

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During this past summer, the Centers for Medicare & Medicaid Services (CMS) announced a major shift in the way Medicare would reimburse hospital services under the program's Diagnosis Related Groups (DRGs) methodology – specifically moving toward severity adjusted DRGs beginning October 1, 2008. While this new approach – dubbed Medicare Severity Diagnosis Related Groups (MS-DRGs) – only applies to Medicare's Hospital Inpatient Prospective Payment System (IPPS) and is separate from physician reimbursement, this change could have a profound impact on Medicare beneficiary access to bariatric surgery for the morbidly obese.

Prior to October 1st bariatric surgery was categorized under a single DRG (288) for obesity. Now, CMS has broken down DRG 288 into three MS-DRG subgroups:

DRG 619 MCC Presence of Major Complication or Co-morbidity

DRG 620 CC Presence of Complication or Co-morbidity

DRG 621 Non-CC No Presence of a Complication or Co-morbidity

This expanded list of categories resulted from CMS reviewing and revising the Complication/Co-morbidity list (CC list), which the agency used to divide certain procedures into two subdivisions based on the presence, or absence of a complication or co-morbidity. Under the new system, CMS will now use the three subdivisions (MCC, CC and Non-CC) that you see highlighted above in the case of obesity surgery.

However, the most troubling aspect of the MS-DRG approach results from CMS revising the CC list and reducing the number of secondary diagnosis codes, which are used to elevate procedures into higher weighted DRG subdivisions, from 3,326 down to 2,583. To make "the list," CMS put through every secondary diagnosis through a

"combination of mathematical data and the judgment of our medical officers, we included the condition on the CC list if it could demonstrate that its presence would lead to substantially increased hospital resource use because of the need for such services as:

- *Intensive monitoring (for example an intensive care unit stay)*
- *Expensive and technically complex services such as heart transplant*
- *Extensive care requiring a greater number of caregivers"*

In terms of chronic conditions and their inclusion on the refined CC list, CMS applied "the criterion that chronic diagnoses having a broad range of manifestations are not assigned to the CC list as long as there are codes available that allow the acute manifestations of the disease to be coded separately."

In addition, this methodology only allows a single co-morbidity to be used in determining the appropriate DRG designation and does not take into account those Medicare patients who often present with multiple co-morbidities as is the case with the morbidly obese. Therefore, the male patient with a Body Mass Index (BMI) of 65, history of Diabetes mellitus, Hypertension, Obstructive Sleep Apnea, and venous stasis dermatitis is a low risk patient in the eyes of CMS and now falls under DRG 621 – the lowest reimbursed DRG for obesity surgery. In fact, according to the present Bariatric Surgery National Coverage Decision issued by CMS in February 2006, Medicare will only cover bariatric surgery in a beneficiary who is morbidly obese (BMI>35) with a minimum of one co-morbidity.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Diagnosis Codes for BMI Covered by Medicare

- V85.35: Patient with a BMI of 35
- V85.36: Patient with a BMI of 36
- V85.37: Patient with a BMI of 37
- V85.38: Patient with a BMI of 38
- V85.39: Patient with a BMI of 39
- V85.4: Patient with a BMI of 40 (class III) and higher

Furthermore, in response to ASMBS's comments on Medicare's proposed policy on Hospital Acquired Conditions (HACs)* regarding surgical site infections following bariatric surgery, CMS stated that

> *"we recognize that patients undergoing this procedure may typically be high risk; however, (1) selecting this procedure as an HAC will have the positive effect of encouraging attention to risk assessment prior to surgery and (2) conditions such as complicated forms of diabetes, hypertensive heart and kidney disease, and a body mass index of 40 or higher are CCs or MCCs under the IPPS payment system that, when present on the claim, will continue to trigger the higher-paying MS-DRG. Thus, the usual presence of additional CC/MCCs on claims for these procedures serves as an "inherent risk adjuster" to payment for typical bariatric surgery cases for obese patients."*

The presence of a disease such as Diabetes mellitus would not move the patient to the next higher DRG grouping. These patients would require an exacerbation of their condition, such as diabetic ketoacidosis with coma in order to be viewed by Medicare as having a major complication or co-morbidity and therefore worthy of the higher reimbursed DRG 619. Of course, no bariatric surgeon would consider operating on a patient with such advanced progression in their diabetes.

Another example is the morbidly obese patient with congestive heart failure. Unless that patient is suffering from acute systolic failure or acute diastolic dysfunction, they would fall under the lowest reimbursed DRG 621 as CMS now views many of the congestive heart failure codes as neither a major or minor co-morbidity worthy of the agency's revised CC list.

Congestive Heart Failure ICD-9-CM Codes that Didn't Make the Cut for Medicare's Revised CC List

428.0:	Congestive heart failure not otherwise specified
428.1:	Left heart failure
428.20:	Systolic heart failure not otherwise specified

428.22:	Chronic systolic heart failure
428.32:	Chronic diastolic heart failure
428.40:	Systolic and diastolic heart failure
428.9:	Heart failure not otherwise specified

Probably the most astounding decision by CMS in implementing its revised CC list is the exception that the agency makes for

> *"diagnosis codes that indicate a chronic disease in which the underlying illness has reached an advanced stage or is associated with systematic physiologic decompensation and debility. The presence of such advanced chronic diseases, even in the absence of a separately coded acute manifestation, significantly adds to the treatment complexity of the patient. Thus the presence of the advanced chronic disease inherently makes the reason for admission more difficult to treat. For example… for obesity, a body mass index over 35 is a CC, but a body mass index between 19 and 35 is not. End-stage renal failure and extreme obesity are examples of chronic diseases for which the advanced stage of the disease is clearly specified."*

In the coming months, ASMBS will be reaching out again to CMS staff to educate them about the contradictory policy that Medicare is now implementing on the hospital side. Medicare patients do not have these medical conditions alone, but in fact suffer from these serious medical conditions in the presence of morbid obesity, while undergoing major abdominal surgery. Therefore, the surgical, anesthetic and nursing care required peri-operatively for these patients is at a much higher level of care than the lean patient with or without these co-morbidities. We clearly believe that many of the secondary diagnosis codes meet CMS's three-prong test outlined above and therefore should be include on Medicare's revised CC list as it relates to bariatric surgery.

**See related Q&A story by Dr. Robin Blackstone on "What ASMBS Members Need to Know About: New Medicare Payment Policy Governing Bariatric Surgery and Hospital Acquired Conditions."*

Click below to view the ASMBS's comments regarding the proposed rule on MS-DRGs

http://www.asbs.org/news/access_comments_msdrg.pdf