

TEFRA payment system for that specific LTCH and 40 percent of the Federal prospective payment amount.

- The 5-year phase-in of the adjustment for differences in area wage levels under § 412.525(c) would not be affected because they are linked to the start of each LTCH's cost reporting period, rather than to the start of the Federal fiscal year. For cost reporting periods that began on or after October 1, 2002 and before September 30, 2003, the applicable LTCH PPS wage index is one-fifth of the full LTCH wage index value, and for cost reporting periods beginning on or after October 1, 2003 and before September 30, 2004, the applicable LTCH PPS wage index is two-fifths of the full LTCH wage index value.

- The LTC-DRGs and their relative weights and the GROUPER would not be affected since they would continue to be updated effective October 1 through September 30 each year based on the changes to the DRGs published in the IPPS final rule.

Section XII. of this proposed rule contains an impact analysis that reflects the impact of these proposed changes.

In summary, we are proposing to amend § 412.535 to indicate that information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates under the LTCH PPS would be published in the **Federal Register** on or before June 1 prior to the beginning of each proposed LTCH PPS rate year beginning July 1. We are proposing that information on the DRG classification system and associated weighting factors, with the DRGs from which the LTC-DRGs are derived, would be published in the proposed IPPS rule and, ultimately, the final rule for the IPPS (the final IPPS rule is published on or before August 1 of each Federal fiscal year).

IV. Proposed Changes in Long-Term Care Diagnosis-Related Group (LTC-DRG) Classifications and Relative Weights

A. Background

Section 123 of Pub. L. 106-113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. L. 106-554 modified the requirements of section 123 of Pub. L. 106-113 by specifically requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the

LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."

In accordance with section 307(b)(1) of Pub. L. 106-554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct long-term care diagnosis-related groups (LTC-DRGs) based on clinical characteristics and expected resource needs. The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs in the IPPS. We apply weights to the existing hospital inpatient DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, we use low volume LTC-DRGs (less than 25 LTCH cases) in determining the LTC-DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to deal with the large number of low volume DRGs (all DRGs with fewer than 25 cases), we group low volume DRGs into 5 quintiles based on average charge per discharge. (A listing of the composition of low volume quintiles appears in the August 30, 2002 final rule at 67 FR 55986.) We also take into account adjustments to payments for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay and classify these cases as short-stay outlier cases. (A detailed discussion of the application of the Lewin Group model that was used to develop the LTC-DRGs appears in the August 30, 2002 final rule at 67 FR 55978.)

B. Patient Classifications into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that payment varies by the LTC-DRG to which a beneficiary's stay is assigned. Cases are classified into LTC-DRGs for payment based on the following six data elements:

- (1) Principal diagnosis.
- (2) Up to eight additional diagnoses.
- (3) Up to six procedures performed.
- (4) Age.
- (5) Sex.
- (6) Discharge status of the patient.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD-9-CM. As of October 16, 2002, a LTCH that was

required to comply with the HIPAA Administrative Simplification Standards and that had not obtained an extension in compliance with the Administrative Compliance Act (Pub. L. 107-105) is obligated to comply with the standards at 45 CFR 162.1002 and 45 CFR 162.1102. Completed claim forms are to be submitted to the LTCH's Medicare fiscal intermediary.

Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a DRG can be made. During this process, the following type of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.6, Radical abdominal hysterectomy, would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare (for example, organ transplant in a nonapproved transplant center).
- Cases requiring more information. (For example, ICD-9-CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 136.3, Pneumocystosis, contains all appropriate digits, but if it is reported with either fewer or more than 4 digits, the claim will be rejected by the MCE as invalid.)
- Cases with principal diagnoses that do not usually justify admission to the hospital. (For example, code 437.9, Unspecified cerebrovascular disease. While this code is valid according to the ICD-9-CM coding scheme, a more precise code should be used for the principal diagnosis.)

After screening through the MCE, each claim will be classified into the appropriate LTC-DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software based on the same GROUPER used by the IPPS. The GROUPER software was developed as a means of classifying each case into a DRG on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). Following the LTC-DRG assignment, the Medicare fiscal intermediary will determine the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments. As provided for under the IPPS, we provide an opportunity for the