

<http://www.cdc.gov/nchs.icd9.htm>.

In conjunction with the cooperating parties of the C&M Committee (AHA, AHIMA, and NCHS), we have reviewed actual medical records and are concerned about the quality of the documentation under the LTCH PPS, as was the case at the beginning of the IPPS. We fully believe that, with experience, the quality of the documentation and coding will improve, just as it did for the IPPS. As noted above, the cooperating parties have plans to assist their members with improvement in documentation and coding issues for the LTCHs through specific questions and coding guidelines. The importance of good documentation is emphasized in the revised ICD-9-CM Official Guidelines for Coding and Reporting (October 1, 2002): "A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task. (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 115)

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section I.B.10 of the Coding Clinic for ICD-9-CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979-55981), we would like to point out that, at Guideline I.B.12, Late Effects, a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has terminated (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 129). We have received question regarding whether a LTCH should report the ICD-9-CM code(s) for an unresolved acute condition instead of the code(s) for late effect or rehabilitation. Depending on the documentation in the medical record, either code could be appropriate in a LTCH. Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such training and

provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 final rule (67 FR 55979-55981).

#### *F. Proposed Changes to the Method for Updating the LTC-DRG Relative Weights*

As previously discussed, under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in accordance with § 412.523(c), we adjust the standard Federal PPS rate by the LTC-DRG relative weights in determining payment to LTCHs for each case.

Under this payment system, relative weights for each LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients who are classified to each LTC-DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. For example, cases in a LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC-DRG with a weight of 1.

As we discussed in the August 30, 2002 final rule (67 FR 55984-55995), the LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2003 were calculated using the March 2002 update of FY 2001 MedPAR data and Version 20.0 of the CMS GROUPEX software. We use total days and total charges in the calculation of the LTC-DRG relative weights.

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such distribution of cases with relatively high (or low) charges in specific LTC-DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate relative weights. We believe this method removes this hospital-specific source of bias in

measuring average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC-DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge. (See the August 30, 2002 final rule (67 FR 55985) for further information of the hospital-specific relative value methodology.)

In order to account for LTC-DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC-DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2003 based on the FY 2001 MedPAR data, we identified 161 LTC-DRGs that contained between 1 and 24 cases. This list of low volume LTC-DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 32 LTC-DRGs ( $161/5 = 32$  with 1 LTC-DRG as a remainder). Each of the low volume LTC-DRGs grouped to a specific quintile received the same relative weight and average length of stay using the formula applied to the regular LTC-DRGs (25 or more cases), as described below. (See the August 30, 2002 final rule (67 FR 55985-55988) for further explanation of the development and composition of each of the five low volume quintiles for FY 2003.)

After grouping the cases in the appropriate LTC-DRG, we calculate the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjust the number of cases in each LTC-DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate "relative adjusted weights" in each LTC-DRG using the hospital-specific relative value method described above. (See the August 30, 2002 final rule (67 FR 55989-55995) for further details on the steps for calculating the LTC-DRG relative weights.)

We also adjust the LTC-DRG relative weights to account for nonmonotonically increasing relative weights. That is, we make an adjustment if cases classified to the LTC-DRG "with comorbidities (CCs)" of a "with CC"/"without CC" pair had a lower average charge than the corresponding LTC-DRG "without CCs" by assigning the same weight to both LTC-DRGs in the "with CC"/"without CC" pair. (See August 30, 2002, 67 FR 55990-55991). In addition, of the 510 LTC-DRGs in the LTCH PPS for FY 2003, based on the FY 2001 MedPAR data, we identified 159 LTC-DRGs for which there were no LTCH cases in the database. That is, no