

stay outlier cases would bring down the average charge for all cases within a proposed LTC-DRG. This would result in an “underpayment” to nonshort-stay outlier cases and an “overpayment” to short-stay outlier cases. Therefore, in this proposed rule, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we adjust for short-stay outlier cases under § 412.529 in this manner since it would result in more appropriate payments for all LTCH cases.

*Step 4—Calculate the proposed FY 2004 LTC-DRG relative weights on an iterative basis.* The process of calculating the LTC-DRG relative weights using the hospital specific relative value methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed LTC-DRG, the proposed FY 2004 LTC-DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed LTC-DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed LTC-DRG relative weights, each LTCH's average proposed relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's proposed LTC-DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed LTC-DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

*Step 5—Adjust the proposed FY 2004 LTC-DRG relative weights to account for nonmonotonically increasing relative weights.* As explained in section II.B. of this preamble, the proposed FY 2004 CMS DRGs, upon which the proposed

FY 2004 LTC-DRGs are based, contain “pairs” that are differentiated based on the presence or absence of CCs. The proposed LTC-DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a proposed LTC-DRG means that cases classified into a “without CC” proposed LTC-DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across “with CC”/“without CC” pairs of proposed LTC-DRGs.

For a case to be assigned to a proposed LTC-DRG with CCs, as we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55990), more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a proposed LTC-DRG “without CCs” (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more) but were not coded completely. Both types of cases are grouped to a proposed LTC-DRG “without CCs” since only one principal diagnosis was coded. Since LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, LTCHs' coding for these cases may not have been as detailed as possible.

Thus, in developing the FY 2003 LTC-DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC-DRG “with CCs” of a “with CC”/“without CC” pair had a lower average charge than the corresponding LTC-DRG “without CCs.” Similarly, based on FY 2002 claims data, we also found on occasion that the data suggested that cases classified to the proposed LTC-DRG “with CCs” of a “with CC”/“without CC” pair would have a lower average charge than the corresponding proposed LTC-DRG “without CCs” for FY 2004.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were

present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a “without CC” LTC-DRG. It would not be appropriate to pay a lower amount for the “with CC” LTC-DRG. Therefore, in this proposed rule, in accordance with the methodology established in that same final rule (67 FR 55990–55991), we grouped both the cases “with CCs” and “without CCs” together for the purpose of calculating the proposed FY 2004 LTC-DRG relative weights. We continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC-DRG pairs. We expect that, as was the case when we first implemented the IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), there are three types of “with CC” and “without CC” pairs that were nonmonotonic, that is, where the “without CC” proposed LTC-DRG would have a higher average charge than the “with CC” proposed LTC-DRG. For this proposed rule, using the LTCH cases in the December 2002 update of the FY 2002 MedPAR file, we identified two of the types of nonmonotonic LTC-DRG pairs.

The first category of nonmonotonically increasing relative weights for proposed FY 2004 LTC-DRG pairs “with and without CCs” contains no pairs of proposed LTC-DRGs in which both the proposed LTC-DRG “with CCs” and the proposed LTC-DRG “without CCs” had 25 or more LTCH cases and, therefore, would not fall into one of the 5 proposed low volume quintiles. For that type of nonmonotonic LTC-DRG pair, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990–55991), we would combine the LTCH cases and compute a new proposed relative weight based on the case-weighted average of the combined LTCH cases of the proposed LTC-DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC-DRG. This new proposed relative weight would then be assigned to both of the proposed LTC-DRGs in the pair. However, as there are no pairs that fall into this category, in this proposed rule, we are proposing that, for FY 2004, there would be zero proposed LTC-DRGs in this category.