

TABLE 2.—PROPOSED NO VOLUME LTC–DRG CROSSWALK AND PROPOSED QUINTILE ASSIGNMENT FOR FY 2004—Continued

LTC–DRG	Description	Cross walked LTC–DRG	Low volume quintile assigned
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5.
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	209	Quintile 5.
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	209	Quintile 5.
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	410	Quintile 3.
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	210	Quintile 4.
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	468	Quintile 5.
516	PERCUTANEOUS CARDIOVASCULAR PROCEDURE W AMI	578	Quintile 3.
520	CERVICAL SPINAL FUSION W/O CC	498	Quintile 3.
525	HEART ASSIST SYSTEM IMPLANT	468	Quintile 5.
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	517	Quintile 4.
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	517	Quintile 4.
528	INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE	1	Quintile 5.
530	VENTRICULAR SHUNT PROCEDURES WITHOUT CC	529	Quintile 2.
531	SPINAL PROCEDURES WITH CC	519	Quintile 4.
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC	534	Quintile 5.
535	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK	515	Quintile 5.
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	253	Quintile 2.
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	401	Quintile 5.

To illustrate this methodology, which was established in the August 30, 2002 LTCH PPS final rule (67 FR 55991), for determining the proposed relative weights for the 164 proposed LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume proposed LTC–DRGs crosswalk information for FY 2004 provided above in Table 2:

Example 1: There were no cases in the FY 2002 MedPAR file used for this proposed rule for proposed LTC–DRG 163 (Hernia Procedures Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that proposed LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to proposed low volume quintile 1 for the purpose of determining the proposed FY 2004 relative weights, would display similar clinical and resource use. Therefore, we are proposing to assign the same proposed relative weight of LTC–DRG 178 of 0.5711 (proposed Quintile 1) for FY 2004 (Table 11 in the Addendum to this proposed rule) to proposed LTC–DRG 163.

Example 2: There were no LTCH cases in the FY 2002 MedPAR file used in this proposed rule for proposed LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that proposed LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to proposed LTC–DRG 91. There were over 25 cases in proposed LTC–DRG 90. Therefore, it would not be assigned to a proposed low volume quintile for the purpose of determining the proposed LTC–DRG relative weights. However, under our established methodology, proposed LTC–

DRG 91, with no LTCH cases, would need to be grouped to a proposed low volume quintile. We identified that the proposed low volume quintile with the closest weight to proposed LTC–DRG 90 (0.7429; see Table 11 in the Addendum to this proposed rule) would be proposed low volume quintile 2 (0.7347; see Table 11 in the Addendum to this proposed rule). Therefore, we are proposing to assign proposed LTC–DRG 91 a proposed relative weight of 0.7347 for FY 2004.

Furthermore, in accordance with the methodology established in the August 30, 2002 final rule (67 FR 55991), we are proposing LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (proposed LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2004 because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified.

Based on our research, as we discussed in that same final rule (67 FR 55995), we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

However, if in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC–DRGs affected. At the present time, we would only include these six transplant proposed LTC–DRGs in the GROUPE program for administrative purposes. Since we use the same GROUPE program for LTCHs as is used under the acute care hospital IPPS, removing these LTC–DRGs would be administratively burdensome.

Again, we note that as this system is dynamic, it is entirely possible that the number of proposed LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume proposed LTC–DRGs and to determine the relative weights in this final rule.

Table 11 in the Addendum to this proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2004.

E. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS. Section 1886(d)(5)(K)(ii)(I) of