

reschedule the effective date and publication cycle of one of the post-acute care prospective payment systems, we should do so for Home Health Agency (HHA) or Skilled Nursing Facilities (SNF) which are not DRG-based, and, therefore, not linked to the October 1 update.

*Response:* As we have noted elsewhere in this final rule, there is no statutory authority requiring the update of the LTCH PPS to coincide with the October 1 start of the Federal fiscal year. On the contrary, annual updates linked to the October 1 start of the Federal fiscal year are required for both the SNF PPS, under section 1888(e)(4)(H) of the Act (implemented in § 413.345), and the HHA PPS, under section 1895(b)(3)(B) (implemented in § 484.225). Therefore, although we do not have the authority to shift the annual update for the SNF PPS or the HHA PPS, we believe that such a policy is appropriate under section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554, which conferred broad authority on the Secretary in designing and implementing a PPS for LTCHs.

*Comment:* One commenter noted that “the use of two GROUPERS will not in and of itself create any hardship on LTCHs [which] will be able to adapt to this process. Most hospitals today do not have fiscal years that coincide with the federal (sic) fiscal year and must adapt to the use of two GROUPERS during their cost reporting year.” This commenter did express concern, however, about the additional rate changes caused by the cost report reconciliation if the proposed outlier policy was finalized. The commenter suggested that we require fiscal intermediaries to update cost to charge ratios either at July 1 or October 1 in order to limit the number of changes during a 12-month period of time.

*Response:* We agree with the commenter’s assessment of most LTCHs’ (and acute care hospital’s) ability to adapt to the use of two GROUPERS during one cost reporting period. Regarding rate changes brought about by changes in our outlier policy, as noted elsewhere in this final rule, all discussions of the outlier policy are presented in the IPPS high-cost outlier final rule.

In this final rule, we 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 will be published in the **Federal Register** on or before May 1 prior to the beginning of each LTCH PPS rate year beginning July 1, unless for good cause we are unable to make

the May 1 publication date, but before June 1. We proposed 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). Section XIV. of this final rule contains an impact analysis that reflects the impact of these changes.

## **V. Changes in Long-Term Care Diagnosis-Related Group (LTC–DRG) Classifications and Relative Weights**

### *A. Background*

Section 123 of Public Law 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 Public Law 106–554 modified the requirements of section 123 of Public Law 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 Public Law 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,