

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 GROUPE. The LTCH GROUPE is specialized computer software based on the same GROUPE used by the IPPS. The GROUPE 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 LTCH to review the LTC-DRG assignments made by the fiscal intermediary and to submit additional information within a specified timeframe (§ 412.513(c)).

The GROUPE is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update. DRG weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient mix than patients in short-term acute care hospitals.

C. Organization of DRGs

The DRGs are organized into 25 Major Diagnostic Categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.)

procedures or groups of O.R. procedures by resource intensity. The GROUPE does not recognize all ICD-9-CM procedure codes as procedures that affect DRG assignment, that is, procedures which are not surgical (for example, EKG), or minor surgical procedures (for example, 86.11, Biopsy of skin and subcutaneous tissue).

The medical DRGs are generally differentiated on the basis of diagnosis. Both medical and surgical DRGs may be further differentiated based on age, sex, discharge status, and presence or absence of complications or comorbidities (CC). We note that CCs are defined by certain secondary diagnoses not related to, or not inherently a part of, the disease process identified by the principal diagnosis. (For example, the GROUPE would not recognize a code from the 800.0x series, Skull fracture, as a CC when combined with principal diagnosis 850.4, Concussion with prolonged loss of consciousness, without return to preexisting conscious level.) In addition, we note that the presence of additional diagnoses does not automatically generate a CC, as not all DRGs recognize a comorbid or complicating condition in their definition. (For example, DRG 466, Aftercare without History of Malignancy as Secondary Diagnosis, is based solely on the principal diagnosis, without consideration of additional diagnoses for DRG determination.)

In its June 2000 Report to Congress, MedPAC recommended that the Secretary “* * * improve the hospital inpatient prospective payment system by adopting, as soon as practicable, diagnosis-related group refinements that more fully capture differences in severity of illness among patients.” (Recommendation 3A, p. 63) We have determined it is not practical at this time to develop a refinement to inpatient hospital DRGs based on severity due to time and resource requirements. However, this does not preclude us from development of a severity-adjusted DRG refinement in the future. That is, a refinement to the list of comorbidities and complications could be incorporated into the existing DRG structure. It is also possible a more comprehensive severity adjusted structure may be created if a new code set is adopted. That is, if ICD-9-CM is replaced by ICD-10-CM (for diagnostic coding) and ICD-10-PCS (for procedure coding) or by other code sets, a severity concept may be built into the resulting DRG assignments. Of course any change to the code set would be adopted through the process established in the

HIPAA Administrative Simplification provisions.

D. Update of LTC-DRGs

For FY 2003, the LTC-DRG patient classification system was based on LTCH data from the FY 2001 MedPAR file, which contained hospital bills received through March 31, 2001, for hospital discharges occurring in FY 2001. The patient classification system consisted of 510 DRGs that formed the basis of the FY 2003 LTCH PPS GROUPE. The 510 LTC-DRGs included two “error DRGs”. As in the IPPS, we included two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are DRG 469 (Principal Diagnosis Invalid as a Discharge Diagnosis) and DRG 470 (Ungroupable). (See the August 1, 2001, Medicare Program final rule, Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education; Fiscal Year 2002 Rates (66 FR 40062).) The other 508 LTC-DRGs are the same DRGs used in the IPPS GROUPE for FY 2003 (Version 20.0).

In the health care industry, annual changes to the ICD-9-CM codes are effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPE software, which are based on the ICD-9-CM codes, are also revised annually and effective for discharges occurring on or after October 1 each year. As discussed earlier, the patient classification system for the LTCH PPS (LTC-DRGs) is based on the IPPS patient classification system (CMS-DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year. The updated DRGs and GROUPE software are based on the latest revision to the ICD-9-CM codes, which are published annually in the IPPS proposed rule and final rule. The new or revised ICD-9-CM codes are not used by the industry for either the IPPS or the LTCH PPS until the beginning of the next Federal fiscal year (effective for discharges occurring on or after October 1 through September 30). (The use of the ICD-9-CM codes in this manner is consistent with current usage and the HIPAA regulations.) October 1 is also when the changes to the CMS-DRGs and the next version of the GROUPE software becomes effective.

As indicated previously in the March 7, 2003, proposed rule, we proposed to make the annual update to the LTCH PPS effective from July 1 through June 30 each year. As a result of this change, we proposed that the LTCH PPS would