

use two GROUTERS during the course of a 12-month period: One GROUTER for 3 months (from July 1 through September 30); and an updated GROUTER for 9 months (from October 1 through June 30). The need to use two GROUTERS is based upon the October 1 effective date of the updated ICD-9-CM coding system. As previously discussed, new ICD-9-CM codes may result in changes to the structure of the DRGs. In order for the industry to be on the same schedule (for both the IPPS and the LTCH PPS) for the use of the most current ICD-9-CM codes, it was necessary for us to propose to apply two GROUTER programs to the LTCH PPS. Although we did not believe that this would have any adverse effect on LTCHs, we were interested in receiving comments on this issue. LTCHs would continue to code diagnosis and procedures using the most current version of the ICD-9-CM coding system.

Currently, for Federal FY 2003, we are using Version 20.0 of the GROUTER software for both the IPPS and the LTCH PPS. For discharges beginning on October 1, 2003 (Federal FY 2004), in the March 7, 2003, LTCH PPS proposed rule, we proposed to use Version 21.0 of the GROUTER software for both the IPPS and the LTCH PPS. Thus, changes to the CMS-DRGs (the DRGs on which the LTC-DRGs are based), and their relative weights, as well as the LTC-DRGs and their relative weights that will be effective for October 1, 2003, through September 30, 2004, are presented in the IPPS FY 2004 proposed rule that was published on May 19, 2003, in the **Federal Register** (68 FR 27154). Accordingly, we will notify LTCHs of any revised LTC-DRG relative weights based on the final DRGs and Version 21.0 GROUTER for the IPPS that would be effective October 1, 2003.

*Comment:* Two commenters suggested that we synchronize the LTCH rate year (that is, July 1 through June 30) with the update of the LTC DRGs which occurs on October 1 by delaying the October 1 update until the following July 1. As an alternative, one commenter suggested that the LTCHs could continue to use the LTC-DRG weights determined the previous October 1 until the start of the next LTCH rate year (July 1, 2004), and conduct a readjustment for the LTCH PPS on July 1 of the following year.

*Response:* With regard to the commenters' suggestion to continue to use the current ICD-9-CM and DRG Grouper Version 20 until June 30, 2004, delaying the update until the following year, we believe that this suggestion is not feasible. This would require coders to use two different ICD-9-CM versions, one for IPPS use (Version 21 will be

implemented October 1, 2003) and another for LTCH PPS. Moreover, the HIPPA (45 CFR part 162) requires that the ICD-9-CM be the standard medical code set and each code set is valid within the dates specified by the organization (Department of Health and Human Services) responsible for maintaining that code set. The use of other than the current code set (most recent update to the ICD-9-CM will be effective October 1, 2003) would be in direct violation of the current HIPPA requirements.

In this final rule, while we are adopting the proposed use of two GROUTER software programs over the course of the LTCH rate year, one GROUTER for 3 months (from July 1 through September 30); and an updated GROUTER for 9 months (from October 1 through June 30), the existing GROUTER and the updated GROUTER will be in effect for 12 months. These two GROUTER programs will be the same programs in use for the IPPS.

#### *E. ICD-9-CM Coding System*

##### **1. Uniform Hospital Discharge Data Set (UHDDS) Definitions**

Because the assignment of a case to a particular LTC-DRG will help determine the amount that will be paid for the case, it is important that the coding is accurate. Classifications and terminology used in the LTCH PPS are consistent with the ICD-9-CM and the UHDDS, as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980") and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services.

We wish to point out that the ICD-9-CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the HIPPA Administrative Simplification Act of 1996 (45 CFR part 162). Furthermore, the UHDDS has been used as a standard for the development of policies and programs related to hospital discharge statistics by both governmental and nongovernmental sectors for over 30 years. In addition, the following definitions (as described in the 1984 Revision of the UHDDS, approved by the Secretary of Health and Human Services for use starting January 1986) are requirements of the ICD-9-CM coding system, and have been used as a standard for the development of the CMS-DRGs:

- Diagnoses include all diagnoses that affect the current hospital stay.

- Principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

- All procedures performed will be reported. This includes those that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

We provide LTCHs with a 60-day window after the date of the notice of the initial LTC-DRG assignment to request review of that assignment. Additional information may be provided by the LTCH to the fiscal intermediary as part of that review.

##### **2. Maintenance of the ICD-9-CM Coding System**

The ICD-9-CM Coordination and Maintenance (C&M) Committee is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, that is charged with maintaining and updating the ICD-9-CM system. The C&M Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The C&M Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in the Tabular List and Alphabetic Index for Diseases, while CMS has lead responsibility for the ICD-9-CM procedure codes included in the Tabular List and Alphabetic Index for Procedures.

The C&M Committee encourages participation by health-related organizations in the above process and holds public meetings for discussion of educational issues and proposed coding changes twice a year at the CMS Central Office located in Baltimore, Maryland. The agenda and dates of the meetings