

can be accessed on the CMS Web site at: <http://www.cms.gov/paymentsystems/icd9>.

All changes to the ICD-9-CM coding system affecting DRG assignment are addressed annually in the IPPS proposed and final rules. Because the DRG-based patient classification system for the LTCH PPS is based on the IPPS DRGs, these changes will also affect the LTCH PPS LTC-DRG patient classification system.

As discussed above, the ICD-9-CM coding changes that have been adopted by the C&M Committee become effective at the beginning of each Federal fiscal year, October 1. Regardless of the change to the annual update of the LTCH PPS year to July 1, coders will use the most current updated ICD-9-CM coding book from October 1 through September 30 of each year. This means that coders and LTCHs that use the updated ICD-9-CM coding system will be on the same schedule (effective October 1) as the rest of the health care industry. The newest version of ICD-9-CM is not available for use until October 1, which would be 4 months after the date that we will publish the LTCH annual payment rate update final rule. The new codes on which the LTC-DRGs are based will go into effect and be available for use for discharges occurring on or after October 1 through September 30 of each year. This annual schedule of the revision to the ICD-9-CM coding system and the change of the ICD-9-CM coding books or electronic coding programs has been in effect since the adoption of Revision 9 of the ICD in 1979.

Of particular note to LTCHs will be the invalid diagnosis codes (Table 6C) and the invalid procedure codes (Table 6D) located in the annual proposed and final rules for the IPPS. Claims with invalid codes will not be processed by the Medicare claims processing system.

3. Coding Rules and Use of ICD-9-CM Codes in LTCHs

We emphasize the need for proper coding by LTCHs. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and produce inappropriate weighting factors at recalibration. We continue to urge LTCHs to focus on improved coding practices. Because of concerns raised by LTCHs concerning correct coding, we have asked the American Hospital Association (AHA) to provide additional clarification or instruction on proper coding in the LTCH setting. The AHA will provide this instruction via their established process of addressing questions through their publication "Coding Clinic for ICD-9-CM". Written

questions or requests for clarification may be addressed to the Central Office on ICD-9-CM, American Hospital Association, One North Franklin, Chicago, IL 60606. A form for the question(s) is available to be downloaded and mailed on AHA's Web site at: www.ahacentraloffice.org. In addition, current coding guidelines are available at the National Center for Health Statistics (NCHS) Web site: www.cdc.gov/nchs.icd9.htm.

In conjunction with the cooperating parties (AHA, AHIMA, and NCHS), we have reviewed actual medical records and are concerned about the quality of the documentation under the LTCH PPS, as was the case at the beginning of the IPPS. We fully believe that, with experience, the quality of the documentation and coding will improve, just as it did for the IPPS. As noted above, the cooperating parties have plans to assist their members with improvement in documentation and coding issues for the LTCHs through specific questions and coding guidelines. The importance of good documentation is emphasized in the revised ICD-9-CM Official Guidelines for Coding and Reporting (October 1, 2002): "A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task. (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 115).

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at section I.B.10 of the Coding Clinic for ICD-9-CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979-55981), we would like to point out that, at Guideline I.B.12, Late Effects, a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has terminated (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 129). We have received a question regarding whether a LTCH should report the ICD-9-CM code(s) for an unresolved acute condition instead of the code(s) for late effect of rehabilitation. Depending on the documentation in the medical

record, either code could be appropriate in a LTCH. Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such training and provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002, final rule (67 FR 55979-55981).

Comment: Two commenters expressed their support for our adherence to the official ICD-9-CM coding guidelines.

Response: We appreciate the commenters support and anticipate working closely with both the AHA and the AHIMA to increase awareness of proper documentation and correct coding in the LTCH setting.

F. Changes to the Method for Updating the LTC-DRG Relative Weights

As discussed in the March 7, 2003, proposed rule, under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in accordance with § 412.523(c), we adjust the standard Federal PPS rate by the LTC-DRG relative weights in determining payment to LTCHs for each case.

Under this payment system, relative weights for each LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients who are classified to each LTC-DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. For example, cases in a LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC-DRG with a weight of 1.

As we discussed in the August 30, 2002, final rule (67 FR 55984-55995), the LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2003 were calculated using the March 2002 update of FY 2001 MedPAR data and Version 20.0 of the CMS GROUPE software. We use total days and total