

rule.) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed in section II.D.4. of this preamble.

#### b. Patient Classifications Into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC-DRG to which a beneficiary's stay is assigned. Similar to case classification for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into LTC-DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the ICD-9-CM.

As discussed above in section II.B. of this preamble, 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. Some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. (See section II.B. of this preamble for further discussion of surgical DRGs and medical DRGs.)

Because the assignment of a case to a particular LTC-DRG will help determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD-9-CM and the Uniform Hospital Discharge Data Set (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 again 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 Administrative Simplification Act of 1996 of the HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated.

Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by the acute care hospitals to ensure accuracy and consistency in coding practices. There will be only one LTC-DRG assigned per long-term care hospitalization; it will be assigned at the discharge. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnostic codes that coexist at the time of admission, that are subsequently developed, or that affect the treatment received. Similarly, all procedures performed during that stay are to be reported on each claim.

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 LTC-DRG can be made.

After screening through the MCE, each LTCH 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 under the IPPS. After the LTC-DRG is assigned, the Medicare fiscal intermediary determines the prospective payment by using the Medicare PRICER program, which accounts for LTCH 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 LTC-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 (as discussed in section II. of this preamble). The LTC-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.

#### 3. Development of the FY 2004 LTC-DRG Relative Weights

##### a. General Overview of Development of the LTC-DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH 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. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the LTC-DRG relative weights in determining payment to LTCHs for each case.

Under the LTCH PPS, 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 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.

##### b. Data

To calculate the LTC-DRG relative weights for FY 2004 in this final rule, we obtained total Medicare allowable charges from FY 2002 Medicare hospital bill data from the December 2002 update of the MedPAR file, and we used Version 21.0 of the CMS GROUPE for IPPS, as discussed in section II.B. of this preamble, to classify cases. Consistent with the methodology under the IPPS, we recalculated the FY 2004 LTC-DRG