

relative weights based on the best available data for this final rule.

As we discussed in the May 19, 2003 proposed rule (68 FR 27151), we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1). Therefore, in the development of the FY 2004 LTC-DRG relative weights, we have excluded the data of the 22 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects.

In addition, as we discussed in that same proposed rule, a data problem regarding the proposed FY 2003 LTC-DRG relative weight values that were determined using MedPAR (claims) data for FYs 2000 and 2001 was brought to our attention. Following notification of this problem, we researched the commenter's claims and determined that, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the reasonable cost-based reimbursement system for the same stay. Based upon our research, we became aware of the following situation: In certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the reasonable cost-based reimbursement system, payment was not dependent upon principal diagnosis, as it is under a DRG-based system. These claims from the MedPAR file were run through the LTCH GROUPE and used in determining the proposed FY 2003 relative weights for each LTC-DRG.

After this issue was brought to our attention, we discovered that only data from the final bills were being extracted for the MedPAR file. Therefore, it was possible that the original MedPAR file was not receiving the correct principal diagnosis. In the August 30, 2002 final rule (67 FR 55989), we addressed the problem by identifying all LTCH cases in the FY 2001 MedPAR file for which multiple bills were submitted. For each of these cases, beginning with the first bill and moving forward consecutively through subsequent bills for that stay, we recorded the first unique diagnosis codes up to 10 and the first unique procedure codes up to 10. We then used these codes to appropriately group each LTCH case to a LTC-DRG for FY 2003.

As we noted above, we are using LTCH claims data from the FY 2002 MedPAR file for the determination of the FY 2004 LTC-DRG relative weights. Since at the time (FY 2002) LTCHs were still reimbursed under the reasonable

cost-based system, some LTCHs also had submitted multiple bills for Medicare payment for the same stay. Thus, in certain LTCHs, hospital personnel were apparently still reporting a different principal diagnosis on each bill since, under the reasonable cost-based reimbursement system in FY 2002, payment was not dependent upon principal diagnosis as it is under a DRG-based system. Therefore, as we explained in the May 19, 2003 proposed rule (68 FR 27151), we are following the same methodology outlined above to determine the appropriate diagnosis and procedure codes for those multiple bill LTCH cases in the FY 2002 MedPAR files, and we are using these codes to group each LTCH case to a LTC-DRG for FY 2004. Since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), we believe that this problem will be self-correcting as LTCHs submit more completely coded data in the future.

c. Hospital-Specific Relative Value Methodology

By nature LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC-DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate the LTC-DRG relative weights instead of the methodology used to determine the DRG relative weights under the IPPS described above in section II.C. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC-DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the hospital-specific relative value method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, averages 1.0 for each LTCH). The

average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established under § 412.523, we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.D.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC-DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight in a LTCH with higher average costs than they would at a LTCH with low average costs which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a \$10,000 charge for a case in a LTCH with an average adjusted charge of \$17,500 reflects a higher level of relative resource use than a \$10,000 charge for a case in a LTCH with the same case-mix, but an average adjusted charge of \$35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Low Volume LTC-DRGs

In order to account for LTC-DRGs with low volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology discussed in the May 19, 2003 proposed rule (68 FR 27176), we group those low volume LTC-DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this final rule, using LTCH