

DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data.”

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the “long-term care diagnosis-related groups (LTC-DRGs). Although the patient classification systems used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect “the differences in patient resource use * * *” of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106-113)).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS-DRGs and the Medicare severity long-term care diagnosis-related groups (MS-LTC-DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development and implementation and rationale for the use of the MS-DRGs and MS-LTC-DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC-DRGs would be considered a reference to MS-LTC-DRGs. For the remainder of this section, we present the discussion in terms of the current MS-LTC-DRG patient classification system unless specifically referring to the previous LTC-DRG patient classification system that was in effect before October 1, 2007.) We believe the MS-DRGs (and by extension, the MS-LTC-DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS-DRGs adopted in FY 2008 represent an increase in the number of

DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In FY 2009, an additional MS-DRG was adopted for a total of 746 distinct groupings (73 FR 48497). For FY 2011, we are proposing to delete one MS-DRG and create two new MS-DRGs, for a net gain of one MS-DRG, as noted in section II. of the preamble of this proposed rule. This would result in 747 distinct MS-DRG groupings for FY 2011. Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS-LTC-DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS-LTC-DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, and as discussed in greater detail below in section VII.B.3.f. of this preamble, we use low-volume MS-LTC-DRGs (that is, MS-LTC-DRGs with less than 25 LTCH cases) in determining the MS-LTC-DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. For purposes of determining the relative weights for the large number of low-volume MS-LTC-DRGs, we group all of the low-volume MS-LTC-DRGs into five quintiles based on average charge per discharge. (A detailed discussion of the initial development and application of the quintile methodology appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for short-stay outlier (SSO) cases (that is, cases where the covered LOS at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS-LTC-DRG). Furthermore, we make adjustments to account for nonmonotonically increasing weights, when necessary. That is, theoretically, cases under the MS-LTC-DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges such that, in the severity levels within a base MS-LTC-DRG, the weights should increase monotonically with severity from the lowest to highest severity level. (We discuss nonmonotonicity in greater detail and our methodology to adjust the RY 2010 MS-LTC-DRG relative weights to account for nonmonotonically increasing relative weights in section VII.B.3.g. (Step 6) of this preamble.)

2. Patient Classifications Into MS-LTC-DRGs

a. Background

The MS-DRGs (used under the IPPS) and the MS-LTC-DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS-LTC-DRGs although they are structurally identical to the MS-DRGs used under the IPPS.

The MS-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). 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 GROUPER software program does not recognize all ICD-9-CM procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKG), or minor surgical procedures (for example, biopsy of skin and subcutaneous tissue (procedure code 86.11)) do not affect the MS-LTC-DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge and that payment varies by the MS-LTC-DRG to which a beneficiary's stay is assigned. Cases are classified into MS-LTC-DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Additional or secondary diagnoses;
- Surgical procedures;
- Age;
- Sex; and
- Discharge status of the patient.

Through FY 2010, the number of secondary or additional diagnoses and the number of surgical procedures considered for MS-DRG assignment was limited to eight and six, respectively. Elsewhere in this proposed rule, however, we are proposing that, for claims submitted on the 5010 format beginning January 1, 2011, we would increase the capacity to process diagnosis and procedure codes up to 25 diagnoses and 25 procedures. This will include one principal diagnosis and up to 24 secondary diagnoses for severity of illness determinations. We refer readers to section II.G.11.c. of this preamble for a complete discussion of this proposed change.

Upon the discharge of the patient from a LTCH, the LTCH must assign