

Clinical Issues

Long-Term Care Hospital
Prospective Payment System

Objectives

- Highlight clinical-related background
- Emphasize importance of correct coding
- Identify responsibility for medical review
- Explore interrupted stay impact on medical record

Background

- Basic clinical information has not changed
- Extended medical and rehabilitative care
 - Clinically complex patients with multiple acute or chronic conditions

Background

- Must meet state licensure requirements for acute care hospital
 - Must also have Medicare provider number and an agreement with QIO
- Subject to FI Medical Review

Patient Sources And Patterns

- Patients generally discharged from acute care hospital
 - Receive a range of services such as:
 - Comprehensive rehabilitation, cancer treatment, head trauma, pain management, respiratory therapy, ventilator management
- Patients less stable upon admission
 - Higher proportion of patient cost associated with ancillary services
 - Pharmacy, Laboratory, Radiology

Patient Classification System

- Balanced Budget Reduction Act (BBRA)
 - Required use of diagnostic-related groups (DRGs)
 - CMS developed patient classification for LTCH PPS
 - Long-term care DRGs (LTC-DRGs)
 - Based on major diagnostic categories (MDCs)

Major Diagnostic Categories

- Classify services based on medical conditions of patients
- Principal diagnostic categorization tool
 - MDC
 - Usually based on single organ system
 - *In general, particular medical specialty*

Major Diagnostic Categories (2)

- Principal diagnosis determines MDC assignment
 - Cases divided into surgical and medical DRGs
 - Procedures performed with some significance
 - Not EKGs, scans, or phlebotomy
 - Medical DRGs do not have significant procedures performed
 - Surgical DRGs assigned based on surgical hierarchy

Long-Term Care DRGs

- Based on existing DRGs used for IPPS
 - Grouped using ICD-9-CM codes
 - Weighted for LTCH resource use

Long-Term Care DRGs (2)

- Patient discharges grouped based on:
 - Patient's principal diagnosis
 - Up to eight additional diagnosis
 - Up to six procedures performed during stay
 - Age, sex and discharge status of patient
- LTC-DRGs found in Table 3 of the August 30, 2002 *Federal Register* starting on page 56076

Coding And Editing

- ICD-9-CM codes reported on claim
- Fiscal Intermediary processes claim based on clinical and demographic information
 - Accurate coding is vital
- Front-end automated screening process
 - Medicare Code Editor (MCE)

ICD-9-CM Coding System

- Changes addressed annually in acute care hospital PPS proposed and final rules
 - Changes effective October 1st each year
 - IPPS changes impact LTCHs
- LTCHs should pay special attention to:
 - Invalid diagnosis codes
 - Invalid procedure codes
 - New diagnosis codes
 - New procedure codes

ICD-9-CM Coding System (3)

- Correctly use **current** ICD-9-CM edition
 - Incorrect coding impacts payment
 - Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and affect the facility's payment
 - Invalid diagnosis codes and procedure codes will not be processed
- **The emphasis on the need for proper coding cannot be overstated**



ICD-9-CM Coding System (2)

- Capture all diagnoses that affect current hospital stay



Principal Diagnosis

- Condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
 - Report same principal diagnosis on every claim submitted for that episode of care
 - Not necessarily same diagnosis for which patient received care at acute care hospital



Secondary/Other Diagnoses

- Secondary or additional
 - 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

Other Diagnoses

- Diagnoses that “develop subsequently” impacts data collection and payment
 - Principal diagnosis remains same throughout claim
 - New conditions that develop should be reported as other diagnosis, and are reported on all subsequent claims



Other Diagnoses

- Diagnosis relating to earlier episode of care and have no bearing on current hospital stay
 - Excluded
 - Do not include on claim

Procedures

- ICD-9-CM procedure code(s) performed during LTCH stay should be reported
 - Surgical in nature
 - Procedural risk
 - Anesthetic risk
 - Specialized training

Medicare Code Editor

- Improperly coded claim(s)
 - Hysterectomy performed on a man
- Surgical procedure(s) not covered by Medicare
 - Organ transplant performed in non-approved transplant facility
- Claim lacks information
 - ICD-9-CM code keyed as three bytes should be four or five bytes
 - *MCE rejects claim*
- Principal diagnosis does not justify admission

Correct Coding Examples

Principal Diagnosis (2)

- Patient discharged from acute care to LTCH
 - Acute care diagnosis stroke
 - 436 Acute but ill-defined cerebrovascular disease
 - LTCH diagnoses is left-sided hemiparesis and dysphasia
 - 438 Late effects of cerebrovascular disease
 - 438.20 Late effects of cerebrovascular disease, hemiplegia affecting unspecified side
 - 438.12 Late effects of cerebrovascular disease, dysphasia

Secondary Diagnosis With No Bearing On LTCH Stay

- Patient discharged from acute care to LTCH
 - Acute care diagnosis pneumonia
 - Pneumonia not treated during stay
 - Do not include on LTCH claim
 - LTCH secondary/other diagnosis
 - Based on conditions during stay
 - Report on all claims from start of condition through discharge

Secondary Diagnoses As Conditions Develop

- Patient discharged from acute care to LTCH
 - LTCH secondary/other diagnosis
 - Decubiti not present on admission
 - *Not included on initial claim*
 - Decubiti exists after initial interim claim period
 - *Decubiti must be included on all future claims up-to and including the discharge claim*

Procedure Codes Performed In Acute Setting

- Patient discharged from acute care to LTCH
 - Procedure codes from prior acute care hospital stay not included on LTCH claim
 - Only procedures performed during the episode of LTCH care should be included on LTCH claim

Procedure Codes Performed In Acute Setting

- Patient discharged from acute care to LTCH
 - Acute care procedure - appendectomy
 - LTCH
 - Appendectomy performed at acute care hospital
 - Do not include appendectomy procedure code on LTCH claim
 - CMS determined only minor surgeries usually performed at LTCH
 - Code LTCH performed procedures on claim

Procedures Performed In The LTCH

- Patient discharged from acute care to LTCH
 - Acute care, no procedures performed
 - LTCH procedures
 - On admission, patient placed on ventilator
 - Patient weaned from ventilator during stay
 - Include ventilator ICD-9-CM procedure code on admission through discharge claim

Procedures Performed In The LTCH (2)

- Patient discharged from acute care to LTCH
 - Acute care, no procedures performed
 - LTCH procedures
 - Laparoscopic lysis of peritoneal adhesions (54.51) not performed on admission
 - Not included on initial claim
 - Procedure code 54.51 must be included on all future claims up-to and including the discharge claim

Quality Improvement Organization (QIO)

- Reviews LTCH admissions and discharges for
 - Medical necessity
 - Reasonableness
 - Appropriateness
 - Outliers
- Validates adequacy and quality of care

Physician Acknowledgement

- Physician's entries in medical record document diagnoses and procedures to determine payment
 - Physicians must complete an acknowledgement statement
- LTCH must have signed and dated acknowledgement from the attending physician on file when claim submitted

Physician Acknowledgement

- Physician must complete acknowledgement at time physician granted admitting privileges at hospital
- Before or at time physician admits first patient
- Existing acknowledgements signed by physicians already on staff remain in effect as long as physician has admitting privileges

Physician Acknowledgement (2)

“Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

Denials Based On Review By QIO

- Services may be denied (in whole or part) under Part A based on QIO determination
 - Misrepresentation of information
 - Unnecessary admissions
 - Subsequent readmission
 - Hospital corrective action

Medical Review By The FI

- Medicare Program Integrity Manual
 - FI responsible for medical review under the LTCH PPS
 - Notwithstanding agreements required between LTCHs and QIO
 - Admission
 - Quality review
 - LTC-DRG review

Furnishing Services Directly Or Under Arrangement

- LTCHs must furnish all necessary covered services to Medicare beneficiaries who are inpatients of the hospital either directly or under arrangements

Furnishing Services Directly or Under Arrangement (2)

- Services must be provided by appropriate clinician
 - Employee of the LTCH or contracted employee
- “...*licensed and/or credentialed in the state where service is performed and working within scope of license...*”

Carrier Billable Services Not Included as Inpatient

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse midwife
- Qualified psychologist
- Anesthetist

Documentation

- Documentation should be:
 - Clear
 - Concise
 - Support services provided during LTCH stay
- Two special payment situations impact clinicians/medical records
 - Short Stay Outliers
 - Interrupted Stays

Short Stay Outliers

- Patients in LTCHs require:
 - Average length of stay in LTCH greater than 25 days
 - Short stay outlier
 - Patient stay is less than $\frac{5}{6}$ average length of stay of the LTC-DRG
 - Received less than full course of treatment for specific LTC-DRG
 - Would be paid inappropriately if paid full LTC-DRG

Short Stay Outliers

- May occur when beneficiary
 - Would receive more appropriate care in another setting
 - Is discharged to home and not readmitted
 - Expires
 - Is at a non-LTCH level of care
 - Requires urgent treatment at another site
 - Receives less than full course of treatment prior to discharge

Short Stay Outliers (2)

- Documentation should be:
 - Clear
 - Concise
 - Support services provided during LTCH stay

Interrupted Stays

- Admitted upon discharge to inpatient acute care hospital, IRF or SNF/Swing Bed and returns to same LTCH within a fixed period of time
 - Becomes one discharge and one payment

Facility Type	Days
Inpatient Hospital	≤ 9
IRF	≤ 27
SNF / Swing Bed	≤ 45

Interrupted Stays (2)

- Cases meeting interrupted stay criteria considered one episode of care
 - Single discharge
 - One LTC-DRG payment
- Policy encourages discharges to another facility to be based on clinical decisions, not financial incentives

Interrupted Stays

- Medical record administrative issue
 - QIO/FI record requests must receive “all” related stay documentation
 - Provider must forward medical documentation for both admissions included in interrupted stay
 - Records must support the LTC-DRG assignment

Interrupted Stays (3)

- Discharges longer than average length of stay for specified facility
 - Subsequent readmission to LTCH considered new admission
 - Two admissions, no change to current medical records process
 - Two claims submitted
 - Two LTC-DRGs assigned
 - Two payments