Characteristics and Challenges of Long-term Acute Care Hospitals

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Governed by somewhat different rules than other acute care providers, long-term acute care (LTAC) hospitals represent a special segment of the provider market. This article reviews the definition of a LTAC hospital and discusses some of the special challenges facing HIM practitioners and coding professionals in this setting.

In addition, we will briefly review the proposed rule for LTAC hospitals (released on January 19 and published in the January 27 *Federal Register*), effective for the Long-term Care Hospital Prospective Payment System (PPS), which begins July 1, 2006. (Note: the Long-term Care PPS is based on rate year, rather than fiscal year, and has a different effective date than other PPS programs.)

LTACs Defined

Long-term acute care hospitals are hospitals that have an average Medicare inpatient length of stay greater than 25 days. Nationally, the average length of stay for LTAC patients is 30 days.[1] Medicare currently recognizes approximately 375 LTAC hospitals, up from 105 facilities in 1993 and 318 in 2003.[2,3] Depending upon the individual state licensing rules, long-term acute care hospitals are licensed as acute care or specialty hospitals.

LTAC hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services usually include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Although patients still require intensive acute care, in general, the care provided in LTAC hospitals is geared more toward therapy and less toward diagnosis than in traditional acute care hospitals.

LTAC hospitals treat patients with:

- Chronic cardiac disorders
- Neuromuscular and neurovascular diseases such as after-effects of strokes or Parkinson's disease
- Infectious conditions requiring long-term care such as methicillin-resistant Staphylococcus aureus
- Complex orthopedic conditions such as pelvic fractures or complicated hip fractures
- Wound care complications (traumatic, pressure, diabetic, and venous)
- Multisystem organ failure
- Immunosuppressed conditions
- Respiratory failure and ventilation management and weaning
- Dysphagia management
- Postoperative complications
- Multiple intravenous therapies
- Chemotherapy
- Pre- and postoperative organ transplant care
- Chronic nutritional problems and total parenteral nutrition issues
- Spinal cord injuries
- Burns
- Head injuries

LTAC hospitals can be free-standing or physically located within acute care facilities. Long-term acute care units located within an acute care hospital are referred to as "hospitals within a hospital." This type of long-term acute care unit must be separately owned and licensed, maintain a separate board and administrative structure, and have a separate medical staff from

its host hospital. Usually under this model, the LTAC unit leases space from the host hospital and purchases ancillary services (e.g., food services, housekeeping, laboratory) from the host. The number of hospitals within a hospital has grown at almost three times the rate of long-term care hospitals in general.[4]

LTAC hospitals opened after May 2005 can have no more than 25 percent of Medicare patients admitted from host hospitals. Although the ruling is effective immediately for new LTAC hospitals, it is being phased in at existing LTAC hospitals.

LTAC Proposed Rule for Rate Year 2007

Since October 2002 LTAC hospitals have been reimbursed under the prospective payment system. Long-term acute care DRGs are the same as acute care hospital DRGs, although the base rate is much higher, reflecting the higher costs of the complex and specialized services.

The most significant change included in the proposed rule relates to reimbursement for short-stay outliers (SSOs), a special subgroup of LTAC patients. SSOs are patients who are discharged early, with hospital costs significantly below average. Under the current reimbursement methodology, payments for SSO cases are based on the lesser of 120 percent of patient costs, 120 percent of the per diem of the LTC-DRG, or the full LTC-DRG payment. Under the proposed rule, the Centers for Medicare and Medicaid Services (CMS) proposes that payments for SSO cases would be the lesser of 100 percent of patient costs, 120 percent of the per diem of the LTC-DRG, the full LTC-DRG payment, or an amount comparable to what would be paid under the Inpatient Prospective Payment System. This change partly reflects the fact that Medicare considers the 37 percent of discharges that qualify as SSO too high a proportion of total LTAC patients.

CMS is proposing that the LTCH PPS federal rate remain at $38,086.04 for the 2007 rate year.[5] In other words, the LTAC reimbursement will be frozen at its current level. There are several reasons for this, two of which seem most significant. Since implementation of the prospective payment system in 2002, Medicare margins have increased steadily. That is, hospitals are making more money on Medicare since the implementation of PPS than before. CMS believes that LTAC payments are increasing without a commensurate increase in case costs. In addition, CMS analysis of the latest available claims data indicates that a significant portion of the 6.75 percent increase in case mix between FY 2003 and FY 2004 is due to changes in coding practices and documentation rather than the treatment of more resource-intensive patients.

LTAC reimbursement guidelines include special considerations for "interrupted stays" of three days or less. The policy is defined as "a stay at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, skilled nursing facility (SNF), or the patient's home and readmitted to the same long-term care hospital within 3 days of the discharge from the long-term care hospital."[6] Presently, all other treatment or care (both inpatient and outpatient) delivered to long-term acute care hospitals in other settings during such an interruption is the responsibility of the LTAC hospital "under arrangements."

To date, surgical services provided in acute care hospitals have been separately reimbursed. This proposal would require that LTAC hospitals cover surgical care provided at an acute care hospital "under arrangements," rather than allowing the acute care hospital to submit a separate bill to Medicare for such treatment. This proposal is based upon the fact that such surgical interruptions represented 0.003 percent of total LTAC discharges and that the total covered charges for those surgical DRGs was $10,294,925, representing 0.1 percent of covered charges to LTAC hospitals for rate year 2005.[7] CMS does not foresee any compromise in quality of care or beneficiary access to appropriate care as a result of this change in reimbursement guidelines.

Coding for LTACs

The ICD-9-CM Official Guidelines for Coding and Reporting as well as the definitions of the Uniform Hospital Discharge Data Set, apply to LTAC hospitals. *Coding Clinic for ICD-9-CM* issued guidelines for LTAC reporting in the fourth quarter 2003 issue, at the specific request of CMS. Depending upon medical record documentation and the specific circumstances of each admission, acute conditions, rehabilitation, or late-effect codes may be assigned as the principal diagnosis. If a patient is admitted to a LTAC hospital for continued treatment of an acute condition, that condition is sequenced as the principal diagnosis. For example, in the case of a patient who has been treated in an acute care hospital for an abdominal wound dehiscence and is transferred to a long-term acute care hospital for continued care of the not-yet-healed wound with

appropriate antibiotic management and debridement as needed, the wound dehiscence (998.32) would be the appropriate principal diagnosis, because its treatment is the focus of admission.

On the other hand, a patient who was admitted to an acute care hospital with a traumatic brain injury and recovers from the acute injury is admitted to a LTAC hospital for rehabilitation consisting of physical, occupational, and speech-language therapy. In this case, because the focus of the admission is rehabilitation, a rehabilitation diagnosis from the V code series (V57.89) would appropriately be assigned as the principal diagnosis.

The definition of principal diagnosis has not changed. It is defined as the reason determined after study to be chiefly responsible for the admission of the patient to the hospital for care. Physician documentation determines the selection of the principal diagnosis. *Coding Clinic* further notes that "because LTCH patients tend to have multiple complex medical problems, the most important secondary diagnoses should be reported as closely following the principal diagnosis as possible (i.e., sequenced within the top eight diagnoses)."[8]

If the exact reason for the admission is unclear, a physician query needs to be submitted. It is as important that LTAC hospitals have effective physician query processes in place as acute care hospitals, perhaps more so, as the documentation in LTAC records can be very extensive, and multiple acute and chronic issues are usually being addressed concurrently. Because LTAC reimbursement is so much higher than that of general acute care hospitals, the effects of any coding errors are amplified accordingly. In this special provider setting, coding professionals need to work closely with medical staffs to ensure that documentation is clear and timely and results in the most appropriate assignment of principal diagnosis to ensure correct reimbursement.

Notes

1. RehabCare. "Long-Term Acute Care Hospital." Available online at www.rehabcare.com/portfolio/long_term_acute_care/default.htm.
2. Centers for Medicare and Medicaid Services (CMS). "Long-Term Care Hospital Prospective Payment System Proposed Rule for Rate Year 2007." Press release, January 19, 2006. Available online at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1757.
3. MedPac. "Defining Long-term Care Hospitals." In *Report to the Congress: New Approaches in Medicare*. June 2004. Available online at www.medpac.gov.
4. Kraspak, John. "Long-term Acute Care Hospitals (LTACHs)." OLR Research Report, December 20, 2004. Available online at www.cga.ct.gov/2004/rpt/2004-R-0966.htm.
5. CMS. "Long-Term Care Hospital Prospective Payment System Proposed Rule for Rate Year 2007."
6. Ibid.
7. Ibid.
8. American Hospital Association. *Coding Clinic for ICD-9-CM* fourth quarter (2003): 103.

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