Coding in Long-Term Care Hospitals: How Medicare Distinguishes LTCHs from Other Providers

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The term "long-term care hospital" (LTCH) can leave some in a quandary—do these facilities provide acute care or long-term care? Many people associate them with skilled nursing facilities.

However, LTCHs are not synonymous with skilled nursing facilities; each has its own rules and regulations. Skilled nursing facilities provide skilled nursing care or rehabilitation services for residents and must meet the requirements for participation in 1819(a)-(d) in the Social Security Act. They must have a transfer agreement with at least one Medicare participating hospital.

LTCHs Defined

LTCHs are for clinically complex patients who have multiple acute or chronic conditions that require extended medical and rehabilitative treatments. Medicare certifies LTCHs as acute care hospitals as part of its condition of participation in the Medicare program. In order for a facility to qualify as an LTCH under Medicare, the average length of stay of a patient must be greater than 25 days, unless the facility qualifies under section 1886(d) of the Social Security Act.

Those facilities that qualify under section 1886(d) must have an average length of stay of greater than 20 days and have 80 percent or more of Medicare discharges with a principal diagnosis of a neoplastic disease process in the 12-month cost-reporting period ending in fiscal year 1997. The Medicare fiscal intermediary or Medicare administrative contractor makes the final determination on a facility's average length of stay.

While the facilities have been certified by the Medicare acute care standards, LTCHs were excluded from a prospective payment system (PPS) until 2002, when the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. These amendments required implementation of a PPS for LTCHs.

Effective October 2002, the Centers for Medicare and Medicaid Services (CMS) established a prospective payment system based on the inpatient diagnostic related groups (DRGs) for long-term care hospitals known as long-term care diagnosis related groups (LTC-DRGs). LTC-DRGs were in effect until October 1, 2007, when CMS revised the DRG system to more accurately reflect severity of illness.

Now the system is known as Medicare severity long-term care diagnostic related groups, or MS-LTC DRGs. This PPS is based on the MS-DRG system that acute care facilities use, with changes to relative weights to account for resource utilization specific to LTCHs.

Coding Guidelines

Since the MS-LTC DRG system is based on the inpatient prospective payment system (IPPS) MS-DRG system, proper selection of principal and secondary diagnosis coding is imperative for accurate DRG assignment. The ICD-9-CM Official Guidelines for Coding and Reporting provide advice on the selection of principal and secondary diagnoses, which LTCHs are required to follow, as the Uniform Hospital Discharge Data Set (UHDDS) definitions are applicable to long-term care hospitals.

The principal diagnosis is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." Secondary diagnoses are defined as "all conditions that coexist at the time of

admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."[1]

Coding professionals should work with their providers to ensure the clear and concise documentation imperative for proper code selection. The 2003 fourth quarter Coding Clinic provides further guidance on principal and secondary diagnosis selection specific to long-term care hospitals. (For example, if a patient is admitted for rehabilitation services, a V57.xx code would be assigned as the principal diagnosis with the underlying condition(s) coded as secondary diagnoses.)

Coding professionals in LTCH settings are faced with similar challenges as coding professionals in the inpatient prospective payment system starting fiscal year 2008. One new challenge is the MS-LTC DRG system that was implemented October 2007.

Part of the new payment system includes a revision to the list of complications and comorbid conditions as determined by CMS. The complication and comorbidity list is mainly comprised of significant acute diseases, chronic diseases with acute exacerbation or those associated with debility, and end-stage diseases. Coding professionals should review the revised complication and comorbidity list to understand how it affects the DRG system.

Short Stay Outliers and Interrupted Stays

Short stay outliers and interrupted stays in long-term care hospitals also affect reimbursement. A short stay outlier is a patient stay that has a length of stay between one day and up to and including five-sixths of the geometric average length of stay for the MS-LTC DRG. If a stay qualifies as a short stay outlier, it is reimbursed at the least of one of four options: 100 percent of the cost of the case; 120 percent of the MS-LTC DRG per diem amount; the full MS-LTC DRG amount; or a blend of the IPPS amount for the DRG and 120 percent of MS-LTC DRG per diem amount.

This payment policy was revised for rate year 2008 for cases where the length of stay is less than or equal to the average length of stay for the same MS-DRG, which is known as the IPPS comparable threshold. These cases will be paid similarly to other short stay outliers, except the IPPS per diem amount, which is multiplied by the length of stay. The key to determining which payment policy will be in place is determining if the short stay outlier exceeds the IPPS threshold.

Interrupted stays occur when patients are discharged to an acute care facility, inpatient rehabilitation facility, skilled nursing facility, or home and readmitted to the same LTCH within a set time period. The time period varies depending on the facility. For example, the timeframe for a patient who is discharged to an acute care facility is up to nine days; the timeframe is up to 27 days for inpatient rehabilitation facility and 45 days for a skilled nursing facility. If the patient is discharged home and readmitted within three days, this is considered an interrupted stay.

Interrupted stays receive one payment for these cases because they are considered one discharge for payment purposes. Long-term care hospitals that are colocated with other Medicare providers such as hospitals within hospitals, satellite facilities, and on-site skilled nursing facilities are subject to the interrupted stay policy. However, if a facility's discharges and readmissions exceed 5 percent for a cost-reporting period, then all readmissions during that cost-reporting period are paid as one discharge regardless of time. CMS defines a hospital within a hospital as part of a hospital that provides inpatient services in a building also used by another hospital or in another building or buildings on the same campus.

Proposed Payment Rate Changes

The payment rates for LTCHs are updated every July 1. This is known as the rate year. The fiscal year updates occur every October 1 and include updates to ICD-9-CM codes and the PPS system. The rate year updates include other information related to calculation of the payment, such as the wage index.

On January 22 CMS released a proposed notice of rule making for updates to the annual payment rates for long-term care hospitals. In this rule CMS proposes consolidating the annual July 1 update to payment rates with the annual October 1 to the MS-LTC DRG so the rate update cycle would be consistent with the fiscal year updates. The rate year 2009 would be extended three months from the normal 12-month cycle if this proposal is accepted as final.

Other proposed changes to payment rate calculations, such as a 3.5 percent market basket update for the 2009 rate year, are outlined in the proposed rule. Proposed revisions to the wage index, labor-related share, the cost of living factors, and outlier thresholds are part of this rule. For a complete description of the proposed changes, go to www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/CMS-1393-P.pdf.

Note

1. Centers for Disease Control and Prevention, National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.

References

Centers for Medicare and Medicaid Services. "Long Term Care Hospital PPS Overview." Available online at www.cms.hhs.gov/LongTermCareHospitalPPS.

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