Long-term Acute Care: the Effect of PPS

by Pam Smith, CCS

Just when I thought I'd seen and done it all in the HIM world, a new opportunity for coders appeared in long-term acute care hospitals (LTCHs). HIM professionals have been employed in LTCHs since the inception of long-term acute care, but the change from cost-based reimbursement to inclusion in the prospective payment system has put coders in the spotlight. Mandated by the Balanced Budget Refinement Act of 1999 and modified by the Benefits Improvement and Protection Act of 2000, the proposed final rule on LTCH PPS was published in March 2003. Not only do coders now play a vital role in this new reimbursement process, they are being recognized for their expertise and knowledge.

I am corporate director of HIM for LifeCare Management Services, a long-term acute care hospital group. Medicare defines a LTCH as a hospital with an average inpatient length of stay greater than 25 days. Typically, LTCHs provide extended medical and rehabilitative care for patients who are clinically complex and suffer from multiple acute or chronic conditions. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment, spinal cord injury treatment, and pain management. LTCH medical record departments have the same requirements as those in acute care. Working out of the corporate office in Plano, TX, my main responsibility is to be a resource to the HIM professionals and other LifeCare staff members.

It Starts with Coding

The LTCH PPS system replaces the TEFRA (Tax Equity and Fiscal Responsibility Act) per diem reimbursement by which LTCHs were previously being reimbursed. In preparation for PPS, LifeCare Management created a PPS team at the corporate level with representatives from reimbursement, HIM, case management, nursing, and administration, among others. At first, we focused on coding accuracy.

To get a baseline for our coding accuracy rate, I visited all the facilities and performed a coding audit. This enabled us to determine which areas needed the most improvement and whether errors were due to coding or physician documentation. Once the audits were completed, we had the data that was needed to present to the facilities.

Next, all hospital administrators were given an overview of PPS. The administrators took this information back to their facilities, where they formed their own PPS committees. Six months later, the HIM directors, coders, case management, and directors of nursing were educated on how we could succeed under PPS as a team. This gave the clinical and professional staffs an important understanding of the HIM world: determining the appropriate ICD-9-CM code for a diagnosis or procedure is not as simple as opening a book and finding the code.

At LifeCare, we've found that teaming a case manager and a coder to work in conjunction with each other has worked well. Coders at LifeCare are involved from the time of admission until the final coding of the record at discharge. Prior to PPS, LifeCare initiated concurrent coding, meaning when the patient is admitted, our coder assigns a working DRG. The coder reviews the chart 24, 48, and 72 hours after the patient's admission.

The coders rely on the case management team as well as the nurses to notify them of any procedures or changes in the patient's condition. The coder then reviews the chart and if needed, adds any appropriate diagnoses or procedures. Because of this important role, our coders are now invited to be a part of team conferences, which are usually only attended by nurses, physicians, case managers, social workers, and therapists.

Smarter, Shorter Documentation

Like acute care facilities, most LTCHs struggle with the completion of the medical records, transcription, release of information issues, and physician documentation. In fact, documentation is the number one issue facing our facilities today.

Whether it is a skilled nursing, acute care, or long-term acute care facility, LifeCare recognized that the physicians would play a very integral part in success under the PPS.

We started with education: medical directors were educated from an HIM perspective on coding and documentation. At first the physicians thought they would have to provide more documentation, but instead we showed them how to document smarter, not harder. For example, we provided samples of the kind of documentation needed to assign codes and illustrated how more specific documentation didn't require more words or more time spent documenting. And in the long run, both coders and clinicians would save time because fewer queries would be needed.

In an effort to provide physicians ongoing education about coding and documentation, LifeCare distributes a weekly coding tip to its facilities. The topics range from similar abbreviations that are coded differently (for example: ARF: acute renal failure or acute respiratory failure) to the rationale on why a particular disease is coded to a particular ICD-9-CM code.

Recently, our North Carolina facility held a staff leadership retreat during which the directors of reimbursement, coding, and case management presented an overview of PPS and how it affects every team in the facility. The presentation was a success and we were invited to other facilities to educate their staff.

Will our vigilance about PPS ever end? At LifeCare, the answer is no. While most of our facilities have made the transition from TEFRA to PPS, coding audits are still being performed. In addition, the HIM staff is assigned continuing education activities. For our facility, this will be an ongoing process to ensure consistency and compliance with PPS.

Living and Breathing Coding: Questions for Pam Smith

Describe your current duties. What are some of your ongoing projects?

I am a resource to our 20 facilities across the United States. This not only includes the HIM department, but other staff within the facilities. I am responsible for every aspect of HIM and serve on different committees that pertain to HIM. In addition, I am responsible for auditing the medical records for coding and documentation issues, whether it be physician, nursing, or therapy services.

How did you come to be in your current position?

I started out in medical records 20 years ago working as a clerk after school. After high school, I joined the hospital full time and held various positions, including ER/OP and inpatient clerk. Then I was offered a position in the home health department as an HIM clerk and coder. After taking a brief break from HIM to work as an admissions supervisor, I returned to HIM. (How can one go from the exciting world of HIM to anything else?)

I moved to a new hospital as a coder and assisted with the suspension process. After five years of coding under my belt and empowered with my CCS, I became the lead coder at another facility and also served as the medical records director in the absence of the director. During this time I taught coding part-time at the community college. Then, I worked for two and a half years as a coding specialist at the Kansas PRO (now QIO), where my duties included reviewing DRG revisions and traveling around the state giving educational workshops on ICD-9-CM and E/M coding. Compliance was in the spotlight at this point, so I took on the position of coding compliance officer. Finally, I found the LifeCare job in AHIMA's job bank. Although I had to relocate for the job, it's been worth it.

If an HIM professional is interested in working in your setting or in a similar role, what kinds of skills/experience should he/she acquire?

I'd suggest at least five years experience in a hospital HIM department with knowledge of all HIM functions. In addition, you'd need a very strong background in coding and coding certification. Being able to work on multiple tasks at one time is key. However, most important is a love for travel. In my position I spend more time in the facilities than I do at the corporate office.

What do you find most rewarding in your job?

The best part of my job is working with the HIM departments at our facilities. I enjoy being a resource to so many different teams within LifeCare. I live and breathe coding and love to share my knowledge with others.

What has been your biggest challenge in this position? How have you met this challenge?

With my travel schedule, the biggest challenge I face is being able to stay in touch with all of the HIM departments and make sure that we are all on the same page. To do this I have monthly conference calls during which all the HIM directors call in and everyone discusses issues they are experiencing and how to resolve them. In addition, I also speak with each HIM director individually each month.

What Does PPS Mean to LTCHS?

The HIM functions in LTCHs share more than a few similarities with acute care and skilled nursing facilities (SNFs), but there are also a few key differences.

The assignment of LTCH DRGs is based on the same six elements as acute care DRGs. In addition, both facilities share the same coding guidelines. However, one of the major differences between LTCH and acute care coding is that LTCHs are treating the late effect of a cerebrovascular accident, brain injury, or aftercare of a fracture or surgery—the patients do not arrive without a diagnosis, as they do in acute care facilities.

For example, when a patient with coronary artery disease (CAD) has a coronary artery bypass graft (CABG), the acute care facility would code the acute phase of the CAD as the final diagnosis. At the time of discharge, if the patient is admitted to a LTCH for continuing care for the non-healing surgical wound, the LTCH would code the non-healing wound as the final diagnosis. Any procedure performed at the LTCH facility is coded by the LTCH facility and not the host hospital. Usually the LTCH does not have surgery or procedure rooms. Instead, the LTCH contracts with the host hospital to perform these types of procedures.

LTCHs are also distinct from SNFs, which are only allowed to code the procedures performed at their facilities. Further, LTCHs are not required to recertify their patients every 30 days as SNFs are. The ICD-9-CM codes are added at recertification and submitted to the fiscal intermediary. In LTCH facilities, the final coding of the record is completed at time of discharge.

LTC-DRGs are classified on clinical characteristics and expected resource needs, just as is the case with the inpatient PPS. LTC-DRGs are weighted higher and have a higher rate of reimbursement to cover the complex patients that LTCHs treat. The acute care facilities use the majority of the 510 DRGs, while LTCH facilities use only about 25 of the 510 DRGs.

For more information on coding guidelines for LTCHs, see the March 7, 2003 *Federal Register*, page 11241, at http://www.gpoaccess.gov/fr/index.html.

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