Long-term Care Hospital PPS Creates Opportunities for Coders: Proposed Rule Addresses Related Coding Issues

by Susan Hull, RHIA, CCS

A prospective payment system has been in effect for Medicare reimbursement for various healthcare providers for almost 20 years. Most recently, long-term acute care hospital (LTCH) facilities have been added to the prospectively reimbursed providers. This is a significant change from the cost-based reimbursement system in effect for these providers until now. This article will explain the background of the LTCH prospective payment system (PPS), changes facilities should now be aware of, and the opportunities these changes present for coders in this sector.

Making the Change

The change from cost-based to prospective payment methodology for LTCHs was mandated by the Balanced Budget Refinement Act of 1999 and modified by the Benefits Improvement and Protection Act of 2000 (BIPA) for implementation for discharges on or after October 1, 2002.

The BIPA requirements mandated that LTCH DRGs be based on the existing acute hospital DRG system, with appropriate modifications in adjustments to relative weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment to account for the particular resource use of LTCH patients. The implementation of the system was authorized in the August 30, 2002, *Federal Register* and the proposed final rule was published in the March 7, 2003, *Federal Register*.

As is typically the case with changes in reimbursement methods, the Centers for Medicare & Medicaid Services (CMS) arranged to phase in the system over five years. During the first year, reimbursement will be 20 percent based on the federal blended rate and 80 percent based on the cost-based reimbursement rate. The percentage of the federal rate will increase each year. By the fifth year, the reimbursement will be based entirely on the federal rate.

Medicare defines LTCHs as hospitals that have an average inpatient length of stay greater than 25 days that typically 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.

History of PPS

LTCHs have been exempt from PPS until now because it was believed that their costs were not comparable to those of acute care community hospitals due to the complexity of their patients and their extended lengths of stay. Because LTCHs were reimbursed based on their costs, there was no incentive for them to exercise cost-control methods. This encouraged inefficiencies in the provision of care, which were believed to have resulted in inflation of Medicare payments to LTCHs. It was because of this that the conversion to PPS was mandated in 1999.

In developing the LTCH PPS, data were reviewed, including Medicare cost reports, individual claims data, and the Online Survey and Certification Reporting System data for 1997. In the development of the final DRGs, MedPAR data from 2001 were used to determine reimbursement.

LTCH DRGs share the following characteristics with all other forms of prospective payment:

- the reimbursement amount is determined in advance of services being rendered and does not change during the fiscal year to which it applies

- actual costs and charges do not affect the PPS reimbursement
- the prospective reimbursement is payment in full for services rendered, and no additional payment may be sought from the beneficiary beyond applicable deductibles and copayments
- the provider becomes responsible for management of care, retaining profits or suffering losses based on the difference between actual costs and the reimbursement

Like acute community hospital inpatient DRGs, LTCH DRGs are based on six elements: principal diagnosis, up to eight additional diagnoses, principal procedure, age of patient, sex of patient, and discharge status of the patient. LTCH DRGs are divided into 25 major diagnostic categories (MDCs), and, within each MDC, into surgical and medical DRGs, just as with the inpatient PPS system used by acute short stay hospitals. The LTHC DRGs contain 510 DRGs, including two "error DRGs": DRG 469 (Principal diagnosis invalid as a discharge diagnosis) and DRG 470 (Ungroupable). The remaining 508 DRGS are identical to those in the inpatient PPS.

CMS proposes to make the effective dates for the LTCH groupers July 1 through June 30, rather than the October 1 through September 30 year familiar to other healthcare providers. Because ICD-9-CM is updated effective October 1, two separate groupers will be required to manage the LTCH PPS.

Currently, the same grouper that is used for inpatient PPS is being used for LTCH DRG management. CMS believes that separating the fiscal reporting periods and update cycles of the LTCHs from the acute hospitals will be a more efficient use of resources.

LTCH PPS and ICD-9-CM

The proposed rule requires that diagnosis code assignment be compliant with the ICD-9-CM coding guidelines as defined in *Coding Clinic for ICD-9-CM* and the definitions of the Uniform Hospital Discharge Data Set, as well as the administrative simplification portion of HIPAA. The following definitions apply:

- Diagnoses include all that affect the current hospital stay.
- Principal diagnosis is defined as the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as 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. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

CMS notes that any changes to the ICD-9-CM coding system recommended by the Coordination and Maintenance Committee and affecting DRG assignment are addressed annually in the inpatient PPS proposed and final rules. Because the DRG-based patient classification system for the LTCH PPS is based on the inpatient PPS DRGs, these changes also affect the LTCH PPS patient classification system.

Though the LTCH DRG year begins on July 1, CMS states that the ICD-9-CM codes that become effective October 1 of each year should be used starting with that date, as the codes are not available in time for implementation on July 1. Two separate groupers will be used to calculate LTCH DRG reimbursement, one for the period of July 1 through September 30, and a second for the period of October 1 through June 30.

Quality of Coding, Documentation

CMS has expressed concern about the quality of the coding and documentation noted in review of LTCH records. CMS notes in the proposed rule that inappropriate coding of cases can adversely affect the uniformity of cases in each LTC DRG and produce inappropriate weighting factors at recalibration.

Long-time coding professionals may recall the effect of inaccurate and inappropriate code assignment during the implementation of DRGs in acute care hospitals approximately 20 years ago. Because of the high resource use in LTCHs, inaccurate coding or inaccurate code sequencing could be even more damaging than it was with acute hospitals.

CMS notes in the proposed rule that it has asked the American Hospital Association to address the issue of appropriate code sequencing for LTCHs in a future issue of *Coding Clinic for ICD-9-CM*. The proposed rule refers the coding professional to

the National Center for Health Statistics' Web site at www.cdc.gov/nchs.icd9.htm for currently applicable coding guidelines.

CMS adds that it expects that these official coding guidelines will be applied by LTCHs as they were applied to acute hospitals. That is, coding and sequencing guidelines for LTCHs do not differ from those of acute community hospitals.

In the proposed rule, CMS specifically addresses several coding issues related to LTCHs, including the appropriate sequencing of late effect codes and continuation of treatment for chronic conditions. LTCHs should access their fiscal intermediaries' Web sites for specific guidance on coding and code sequencing.

A Unique Opportunity for Coders

The implementation of LTCH DRGs represents an important change in reimbursement for these facilities with potentially negative effects on fiscal health. As a result, coding professionals in this setting have a unique opportunity to take a prominent role in preparing the hospital to prosper under prospective payment. This can be achieved by careful analysis of current coding and documentation practices, development of strategies for improvement where needed, and monitoring the effects of improved coding and documentation practices.

Reference

More information on reimbursement is available on the CMS Web site at http://cms.hhs.gov/providers/longterm/ default.asp.

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Article citation:
Hull, Susan. "Long-term Care Hospital PPS Creates Opportunity for Coders: Proposed Rule Addresses Related Coding Issues." *Journal of AHIMA* 74, no.6 (June 2003): 58-60.