New PPS Proposed for LTC Hospitals

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by Michelle Dougherty, RHIA

In the past 10 years, the number of new long-term care hospitals (LTCHs) in the United States has tripled. Because of this growth, LTCHs are the newest post-acute settings to face a change in the reimbursement system.

While there are only about 270 LTCHs in the United States, the Medicare Advisory Commission (MedPAC) reported to Congress that LTCHs have grown faster than any other exempt hospital provider, both in number of facilities and amount of reimbursement.

On March 22, 2002, the Centers for Medicare and Medicaid Services (CMS) published proposed rules for a new prospective payment system (PPS) in LTCHs. Congress required the secretary of the Department of Health and Human Services to implement a new system by October 1, 2002, and base it on existing hospital DRGs if feasible.

Who Is Included?

This new PPS for LTCHs applies to facilities that have been exempt from the current acute care DRG system. The following types of providers were excluded because the system did not take into account the unique type of treatment provided or adequately reimbursed for services:

- rehabilitation hospitals (including units in acute care hospitals)
- psychiatric hospitals (including units in acute care hospitals)
- LTCHs
- children's hospitals

An LTCH differentiates itself from an acute care hospital by entering into a special agreement with Medicare and maintaining an average length of stay greater than 25 days (20 days for those facilities excluded from acute care PPS in 1986). In the past, the average length of stay was calculated for the entire inpatient population (not just Medicare patients) over a cost report year. The proposed rule changes the criteria by calculating the 25-day average length of stay for Medicare patients only.

A New System

CMS contracted with two companies to develop a DRG-based model for the new reimbursement system. CMS selected a model created by the Lewin Group, known as LTC-DRGs, which was created by tailoring the existing acute hospital DRG system to reflect LTCH attributes.

The proposed system is comprised of 501 LTC-DRGs. There are two very short-stay DRGs (one for psychiatric and one for other cases with a length of stay seven days or less) and two error DRGs. The other 497 are the same as the DRGs used in the hospital inpatient PPS grouper for 2002. An LTC-DRG classification is based on the principle diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. Additional criteria used to determine the appropriate LTC-DRG include the patient's age, sex, and discharge status.

Coding Concerns

Because the reimbursement level is based primarily on ICD-9-CM coding, the accuracy of coded data will be critical for LTCHs. CMS typically avoids issuing coding advice in the *Federal Register*, but felt it was necessary after analyzing the coded data submitted by LTCHs. The proposed rule identified a handful of coding errors and reiterated the proper method for assigning codes in the following situations:

- The **principal diagnosis** in an LTCH may not be the same as in an acute care hospital. Specifically, reporting codes for a stroke patient is addressed in the *Federal Register*. The rule directs the coder to use 438 if a patient was admitted to an acute care hospital for treatment of a CVA (cerebral vascular accident) and then subsequently admitted to an LTCH. Because 436 is only to be used for the initial episode of care, an LTCH cannot report the acute CVA code when the patient was previously treated.
- Diagnoses that do not **have an effect on the stay** do not need to be coded and reported as secondary diagnoses. The example provided was a patient who had pneumonia treated in a previous facility but was resolved before admission to the LTCH. Because the LTCH was not treating pneumonia, it should not be coded and reported.
- **Procedure codes** that reflect procedures done during a **previous acute care hospital stay** should not be reported by the LTCH. The example provided was a patient who had an appendectomy and was admitted to an LTCH following a hospital stay for medical treatment following surgery and other complicating conditions. The appendectomy should not be coded and reported because it was not performed in the LTCH.

Accuracy of documentation, diagnosis, and procedure coding will be critical to success under PPS. HIM professionals can lead the way and use their experience with DRGs to help guide facilities as they make the transition to a new payment system.

Reference

Federal Register 67, no. 56, March 22, 2002; p. 13416-13494.

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