

Long Term Acute Care Hospital

Caring for patients with chronic and long term care needs is becoming increasingly more important as our society ages. A long term acute care hospital (LTACH) is a vital entity within a comprehensive health care continuum. Long term acute care hospitals can be free-standing or physically located within existing acute care facilities as a "hospital within a hospital"².

Long term acute care hospitals, which are recognized by Medicare as per 42 CFR 412.23(e), generally provide diagnostic and medical treatment or rehabilitation to patients with chronic diseases or complex medical conditions. The aggregate Medicare average length of stay must exceed 25 days. This is the only additional Medicare condition of participation that sets LTACHs apart from acute care hospitals.

A long term acute care hospital is exempt from the Prospective Payment System (PPS). LTACHs are paid under LTC-DRG's which have the same definitions as short term acute DRG's but have different relative weights applied to a higher base rate.

A comprehensive master plan to develop a LTACH shall address State Hospital Licensing Requirements as follows:

- Federal Regulatory Compliance
- Organizational and Governance Compliance
- Reimbursement Models Based on Case Mix
- Bed Allocation and Methodology
- Product Line Structuring
- Functional Space Design
- Operational Budget and Staffing Requirements
- Medical/Nursing Staff Education and Orientation

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LTACH DEMONSTRATION AUDIT ALERT - GUIDANCE FOR HOSPITALS

Murer Consultants has long been committed to effective documentation and coding as well as compliance with medical necessity requirements. Murer Consultants is currently working with LTACHs across the nation in handling denials and appeals resulting from the Long Term Care Hospitals (LTCH) Demonstration Project. This briefing provides some key background information, feedback from the auditor, and appeals details.

Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Pub L. 110-173, and specifically section 114(f), provided for expanded review of medical necessity for admission and continued stay at Long Term Care Hospitals (LTCHs).

The Centers for Medicare & Medicaid Services (CMS) awarded a contract to Wisconsin Physicians Service (WPS), which merged with Mutual of Omaha in 2005, to perform medical review of LTCH claims to determine a National Error Rate for LTCHs. WPS uses existing inpatient hospital review criteria in order to determine the medical necessity of admission.

WPS requests LTCH claims for medical review from LTCH providers. The requested claims must be sent directly to WPS in Omaha, Nebraska as instructed in the request for records letter. If the requested documentation is not submitted or not submitted in a timely manner, a denial for breach of Medicare contract is issued and a denial code of 56900 is implemented. Only claims that have been reviewed and denied for medical necessity are afforded appeal rights.

WPS is conducting medical reviews on all LTCH facilities whether or not WPS is the assigned adjudicating contractor (FI) for that provider. WPS will send the initial medical review determination decision to the provider's adjudicating contractor. That adjudicating contractor will notify the provider of the findings and adjudicate the claim including collecting any overpayments.

The provider must submit any appeal requests to their adjudicating contractor. WPS will then supply the adjudicating contractor the original claim for the appeal process.

Feedback

Recently, we have received feedback from one of the LTACH facilities we manage that the first two LTCH Demonstration audit charts that were submitted to WPS for medical review have been denied. The WPS team of medical professionals determined that the claim was fully denied because there was "insufficient documentation submitted to support services medically reasonable and necessary."

Two specific denial grounds provided included the following:

- Documentation does not support a completed pre-assessment and/or validation within 48 hours of admission; and
- Documentation does not support interdisciplinary team treatment, including physicians, prepared and/or carried out individualized treatment plan.

Murer Consultants contacted the WPS audit supervisor requesting clarification on the interpretation of these issues in order to provide ongoing guidance to its LTACH clients. It appears WPS is applying an extremely strict and narrow interpretation to these regulations and

making full denials of otherwise valid and medically necessary claims due to technicalities within the medical records.

Murer Consultants always encourages continual pre-assessment of LTACH appropriate patients through the case management/case finding process. However, it is critical for LTACHs to ensure that all case managers complete pre-assessment screenings on potential LTACH patients and ensure that a validation for LTACH appropriateness occurs within 48 hours of admission. It is imperative this pre-screening is evidenced within the LTACH medical record. Thus, any care assessment documentation for LTACH appropriate admissions must occur within the LTACH patient chart, not just in the short term acute chart.

Additionally, Murer Consultants has always believed that interdisciplinary team treatment is effectuated through physician care directed in the physician orders section of the medical record, respiratory, occupational, and physical therapy notes, and nursing notes. There is no evidence of specific interpretation related to "interdisciplinary team treatment." When questioned on this issue, WPS stated that is essential to have documentation demonstrating interdisciplinary treatment with a physician "driving the bus." It is not sufficient to only have separate disciplines documenting in the medical record in a silo-like fashion. There must be documentation demonstrating that all disciplines are working together in the development and modification of patient treatment plans on an ongoing basis. Murer Consultants will work with all LTACHs to ensure that this requirement is met from this point forward.

Appeal Process

For those LTACHs receiving denials as a result of the LTCH demonstration audits conducted by WPS, all appeals must be handled in the same manner as any Medicare claim denial. WPS will only adjudicate those claims over which it has jurisdiction as a fiscal intermediary. It is imperative to note that denials are not subject to immediate recoupment. Recoupment of payment for denied claims will occur on the 41st day after receipt of a demand letter outlining the provider's rebuttal rights.

Following is an outline of the five levels of appeal in the Medicare appeals process:

- Redetermination by an FI, carrier or MAC (Medicare Administrative Contractor)
- Reconsideration by a QIC (Qualified Independent Contractor)
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board (Appeals Council)
- Judicial review in U.S. District Court

NOTE: A redetermination is an examination of the initial claim decision. A request for a redetermination must be submitted in writing within 120 days of receipt of the initial claim determination. Murer Consultants contacted one fiscal intermediary (Trailblazer) which stated

no recoupment will occur if a redetermination appeal is on file within 30 days of receipt of the demand letter.

Thus, should you receive any denials resulting from the LTCH Demonstration audit conducted by WPS and require information and assistance on handling the denials and appeals process, please immediately contact our office for assistance.

All LTACHs should complete a detailed review of the documentation within the hospital's medical record. Re-assessment of the issues discussed above as well as a full documentation review is critical to ensure no future denials occur.

Not only can Murer Consultants help clients manage denials from the LTCH demonstration audit, Murer also is assisting clients in preparation for the government's Recovery Audit Contractor (RAC) Initiative to ensure that facilities receive full payment for rendered services. Specifically Murer provides consultation in the following key areas:

- Ensuring that services are appropriately documented to demonstrate that they were medically necessary and meet the Medicare medical necessity criteria for the setting where the service was rendered;
- Ensuring services that are correctly coded;
- Assisting providers to submit sufficient documentation to support Medicare claims ;
- Conducting educational seminars for providers on proper documentation and coding techniques.

Murer Consultants is committed to working with hospitals and physicians to cooperatively ensure high levels of clinical documentation, which will in turn assure full payment from Medicare.