

The LTCH Special Project: Frustration and Confusion for Providers

By John A. Mills, Esq.

On February 17, 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the Long Term Care Hospitals (LTCHs) Special Project (the Special Project). The Special Project calls for an expanded medical necessity review of admissions and continued stays at LTCHs for claims going as far back as October 1, 2007. As the Special Project unfolds, it is becoming clear that, like the Recovery Audit Contractor (RAC) demonstration program, auditors are taking an aggressive approach in their review of claims, and are using the results of their reviews to disallow claims. For LTCHs, there is a lot at stake with the Special Project, because it appears fueled by a perception at CMS that LTCHs are too costly to the Medicare program.

Background Regarding the Special Project

The Special Project stems directly from the enactment of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act (MMSEA) of 2007. Section 114(f) of the MMSEA charged CMS with the task of annually reviewing the medical necessity of admissions and continued stays at LTCHs for discharges on or after October 1, 2007, in a manner that has error rate calculation and guarantees that at least 75 percent of overpayments for those deemed unnecessary are identified and recovered, and that related days of care will not be counted toward the average length of stay requirement for LTCHs. Although Section 114(f) of MMSEA calls for the Special Project to cease for discharges occurring on or after October 1, 2010, the legislation nonetheless gives

CMS the authority to determine whether to continue its medical necessity review and recovery of at least 75 percent of overpayments received by LTCHs.

Change Request 6324, issued by CMS earlier this year, provides a basic framework for how the Special Project is supposed to be conducted. One of the first steps is for the LTCH Sampling Contractor, AdvanceMed, to select an annual universe of claims to be reviewed, which is then communicated to Wisconsin Physicians Services (WPS), the contractor conducting the review, as well as Fiscal Intermediaries (FIs), and Part A and B Medicare Audit Contractors (MACs). WPS conducts the review by gathering information regarding claims from providers, and then notifies the FIs and MACs of the outcome of the review. More often than not, the reviews are resulting in FIs and MACs notifying the provider of an alleged overpayment. Providers are afforded 120 days to appeal from the date of the letter. In many cases, WPS has also been notifying the overpayment provider, so that LTCHs are receiving letters from multiple sources alleging the same overpayment. This is causing confusion among the provider community, since these letters are often sent at different times and provide conflicting information about how the provider can appeal the overpayment determination.

WPS and other contractors have been notifying providers of claim denials and overpayments on the basis that the services were not medically necessary to be provided at the long term care hospital level. This typically consists of WPS alleging that entire stays at the LTCH are

not medically necessary at an inpatient level, or that patients' conditions were not medically complex enough to satisfy LTCH admission criteria, or (usually) both. WPS has also been alleging that the documentation concerning the claim does not show compliance with the definition of a long-term care hospital that was enacted by Section 114(a) of MMSEA. That definition requires, among other things, that the hospital have an average inpatient length of stay greater than 25 days; that the hospital's patients have 'medically complex conditions' requiring a long hospital stay; that a stringent 'patient review process' be in place to determine appropriate admissions, that hospitals validate that patients meet 'admission criteria for long-term care hospitals,' with regular evaluations for continuation of long-term care and the assessment of discharge options; and that the hospital provides an interdisciplinary team of healthcare professionals preparing and carrying out an individualized plan of care. See 42 U.S.C. § 1395x (ccc).

Establishment of LTCH Facility and Patient Criteria

In addition to calling for medical necessity review for discharges on or after October 1, 2007, and providing a statutory definition of long-term care hospitals, Section 114 of the MMSEA also called for CMS to conduct a study on the establishment of national facility and patient criteria for determining medical necessity, appropriateness of admission, continued stay at, and discharge from LTCHs. The legislation requires CMS to submit a report of its findings to Congress no later than 18 months from December 29, 2007, the date of enactment of the

MMSEA.¹ The legislation also requires that the study and report take into account MedPAC's recommendations to Congress in a 2004 report that LTCHs be (1) defined by facility criteria with features such as staffing, patient evaluation and review processes, and patient mix, and (2) defined by patient criteria that identify specific clinical characteristics and treatment modalities.

Shortly after the MedPAC report, CMS contracted with the Research Triangle Institute (RTI) to evaluate the feasibility of establishing facility-level and patient-level criteria for LTCHs. RTI has to date performed its work in three phases, with the reports for Phase I and II currently available on the CMS website. Consistent with the MedPAC reports, as well as CMS's own pronouncements on the subject, RTI's research results have suggested that LTCH cases are not uniquely distinguishable from those in other acute care settings, and that the types of cases treated in LTCHs may also be treated in IPPS hospitals or IRFs. In the FY 2010 LTCH PPS proposed rule (74 FR 24231), CMS noted that for Phase III, a panel of experts had reviewed RTI's findings and recommended that Medicare establish "Centers of Excellence" for treating medically complex or critically ill patients, which could be LTCHs, but could also be other facilities with the staffing and resources to treat these types of cases. CMS did not have anything further to add on the subject in the FY 2010 LTCH PPS final rule, but noted that RTI's Phase III report would be available on the CMS web site in the near future and that any policies being considered for implementation would be subject to the notice-and-comment rulemaking process.

The Importance of Appealing Adverse Determinations

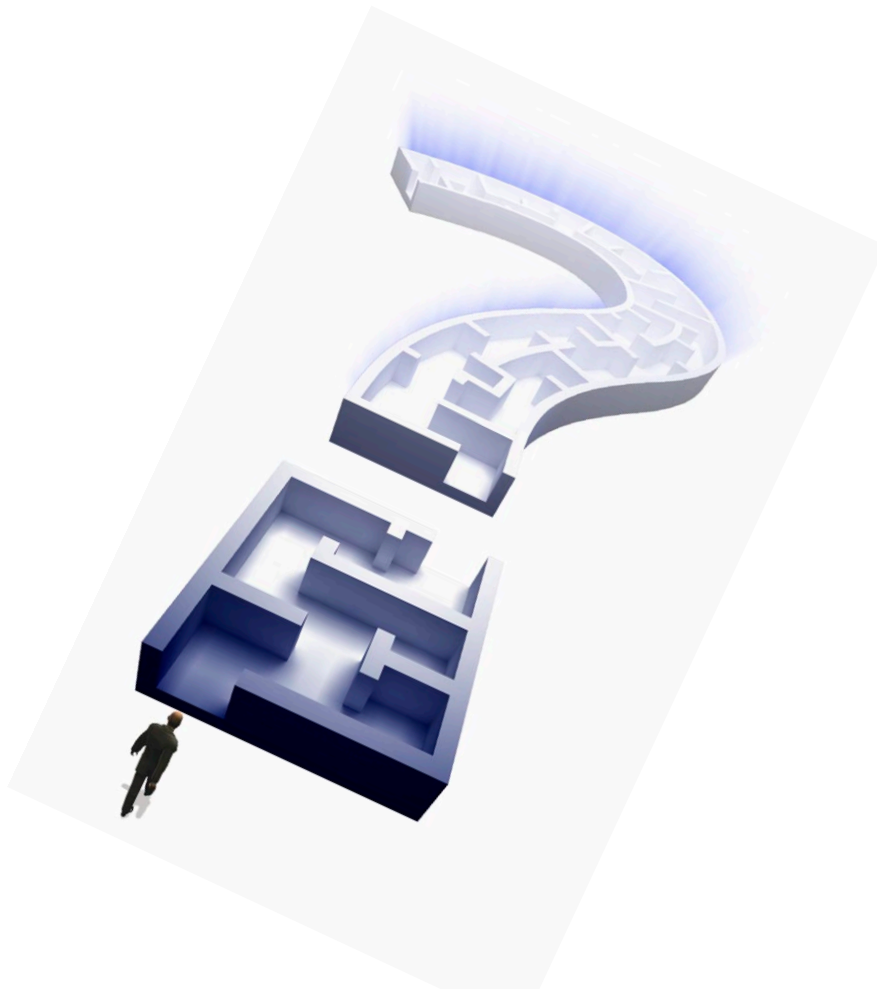
Given the federal government's recent talk about establishing national facility and patient criteria for LTCHs, it has been the expectation and hope of many in the provider community that the rigorous auditing of LTCH claims would facilitate the setting of such criteria. However, since the implementation of the Special Project, the provider community is quickly realizing that the audits are being

used primarily for disallowances and overpayment recovery. Curiously, the fact that WPS is disallowing claims largely because the patient's care is not sufficiently medically complex presents somewhat of a cart-before-the-horse scenario.

The MMSEA may have called for the medical necessity reviews, but it only nominally helped define patient coverage criteria, and only then prospectively from the date of passage. Its call for CMS to further define patient criteria has, to date, not occurred. Thus, if patient care subject to the Special Project reviews is to be judged, arguably judgment should be based on standards that existed at the time the care was provided, before and after the MMSEA went into effect. However, the regulations presently do not define or limit the types of patients or conditions that are appropriate for treatment by LTCHs, and CMS itself has emphasized that there are no distinguishing case features for determining whether care should be delivered at a short-term acute-care hospital or LTCH.

At the heart of CMS' recent focus on LTCHs is its historical lack of understanding of the role of LTCHs in the continuum of care, and its skepticism about certain LTCHs within the industry. Thus, the Special Project will likely be far reaching and have broad implications, including perhaps even the future participation of LTCHs in the Medicare program. For these reasons, LTCHs are finding that it is important to appeal adverse claims reviews by WPS, and to closely examine their admissions and medical necessity criteria, in order to show that the level of care being provided at LTCHs is not interchangeable with that provided at other types of facilities. **NP**

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¹ CMS has said that it intends to post the report on its website once it has been submitted to Congress; however, at the time this article was written, the report had not been posted.