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Client Alert

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UPDATE ON CMS' MEDICAL REVIEW ACTIVITIES FOR LONG TERM CARE HOSPITALS

As of January 1, 2009, the Centers of Medicare and Medicaid Services (CMS) implemented several important medical review activities that could significantly affect Long Term Care Hospitals (LTCHs). Specifically, there are new statutory requirements directing CMS to study the feasibility of establishing clear admission criteria for LTCH patients, given Congress' focus on reports from the Medicare Payment Advisory Commission (MedPac) that there were no clear standards.

CMS has recently initiated expanded medical necessity reviews of LTCHs pursuant to the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) which was signed into law on December 20, 2007. The MMSEA provides for expanded review of Medicare claims data by fiscal intermediaries and Medicare administrative contractors to ensure that:

- LTCHs only admit high-acuity, medically complex patients; and
- LTCH patients are discharged to other less costly Medicare covered settings, such as skilled nursing facilities, inpatient rehabilitation facilities and short-term acute care hospitals, as soon as they have sufficiently recovered.

Accordingly, under section 114(b) of MMSEA, the Secretary of Health and Human Services is charged to study the feasibility of establishing national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, LTCHs. Information obtained from initial medical necessity reviews and patient sampling and validation will likely be used as a basis for the report to Congress and for developing national LTCH facility and patient criteria. To accomplish this goal, CMS issued a bid to solicit contractors for the project.

LTCH MEDICAL NECESSITY REVIEW CONTRACTORS NAMED

On December 19, 2008, CMS announced that it had awarded two contracts to perform a limited number of medical necessity reviews of LTCHS claims across the country beginning January 2009. As required by section 114(f) of MMSEA, the medical necessity reviews must provide for a statistically valid and repre-

sentative sample of admissions of such individuals sufficient to provide results at a 95% confidence interval; and guarantee that at least 75 percent of overpayments received by LTCHs for unnecessary admissions or stays in LTCHs will be recovered, and ensure that related days of care are not counted toward the LTCH 25-day length of stay requirement.

CMS awarded the first contract to AdvanceMed to perform LTCH sampling and validation. The second contract was awarded to Wisconsin Physician Services (WPS) to conduct post-payment medical reviews of LTCH claims to identify the rate at which claims were paid in error. WPS will use existing inpatient hospital review criteria in order to determine the medical necessity of admission. Importantly, only discharges that occur on or after October 1, 2007 and before Oct. 1, 2010 are subject to the error rate determination. The information collected by WPS and AdvanceMed will allow CMS to develop a national error rate for medically unnecessary patient admissions to LTCHs, and may be shared with recovery audit contractors, fiscal intermediaries and quality improvement organizations for the purpose of recovering Medicare payments.

Notably, the costs of the new LTCH medical necessity reviews will be funded from the aggregate overpayments recouped from the providers, with the only limitation that the costs of the program may not exceed 40% of recovered overpayments.

While the information gathered as a result of the expanded medical necessity reviews and the LTCH sampling and validation will be useful for allowing contractors to recover overpayments and will serve as a benchmark which will help CMS contractors determine if future or additional review is necessary, LTCHs may likely see an increase in denials based on medical necessity and an increase in findings of overpayment. Further, in the wake of the controversy and anxiety surrounding the Recovery Audit Contractor (RAC) Program, LTCHs have reason for concern regarding the expanded medical necessity reviews. Moreover, like the RAC program, compensation of the medical necessity reviews will be derived from overpayments recouped by the contractors. A major concern of the RAC program by healthcare providers has been the contingency fee compensation structure of the RACs which is based on denials and overpayments. LTCH facilities will justifiably have the same concern because payment to AdvanceMed and WPS will be based on overpayments recouped.

OTHER CHANGES IN LTCH CLAIM REVIEWS

This new initiative for postpayment review follows on the heels of other changes in claims review for LTCHs. Specifically, in August 2008, the fiscal intermediaries (FIs) and Part A/Part B Medicare Administrative Contractors (A/B Macs) replaced the Quality Improvement Organizations (QIOs) in performing medical review for acute Inpatient Prospective Payment System Hospital (IPPS) and LTCH claims.

FIs and MACs will apply coverage, coding, and medical necessity guidelines, utilizing clinical judgment in making payment determinations on each LTCH claim reviewed, just as the QIOs did. Although the QIO

reviews were conducted in a peer review manner by physicians, the FI and MACs are not required to have physicians performing these audits. Instead, CMS has stated that the reviews will be conducted by qualified clinicians, such as nurses and therapists, and consulting physicians when necessary.

ONGOING CHALLENGES

CMS noted in its announcement awarding the contract to perform expanded medical necessity reviews that WPS will use existing inpatient hospital review criteria in order to determine the medical necessity of an admission. It is unclear, however, what exact standard will be applied in determining the medical necessity of an LTCH patient admission. Clearly, the lack of standards or guidance in the criteria medical necessity concerns LTCH stakeholders. Even CMS has recognized, "while by definition, the patients appropriate for treatment in a LTCH require hospital-level care, it is not clear that any criteria can be developed which identifies patients who belong in a LTCH exclusively." Therefore, the LTCHs may have to prepare to appeal denials and provide detailed records and evidence to support their positions that patients met admission criteria. Moreover, LTCHs may consider improving documentation procedures to address any issues identified through internal audits or medical reviews as well as including detailed information on admission records explaining why a patient needs LTCH services and not admission to an acute care hospital or a skilled nursing facility or other setting.