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Client Alert

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OIG Issues Warning to LTCHs

On March 6, 2013, the Office of Inspector General (OIG) for the Department of Health and Human Services issued an alert memorandum regarding long-term care hospitals (LTCHs) that are located in the same building or on the same campus as another hospital-level provider or skilled nursing home. In the memorandum, the OIG warned that co-located LTCHs must ensure that they have properly reported their co-located status to their Medicare Administrative Contractors or fiscal intermediaries because an inaccurate status report could result in overpayment of reimbursement for services provided to patients.[1]

LTCHs treat patients who have been discharged from acute care hospitals but have complex medical conditions that require prolonged hospital-level care.[2] An LTCH can be freestanding or co-located with another hospital-level provider (e.g., an acute care hospital) or a skilled nursing facility. A co-located LTCH is located in the same building as another provider or in a separate building on the same campus as another provider.[3] Co-located LTCHs must notify their claims processing contractors within **60 days** about the providers with which they are co-located and whether there are any changes in their co-located status. 42 C.F.R. § 412.532(i). To qualify as an LTCH for Medicare payment, a facility must meet Medicare conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare beneficiaries.[4] Because co-location creates incentives for providers to make decisions about admitting and discharging patients on the basis of maximizing Medicare payments, CMS developed two payment policies – (1) the 25% Threshold Rule and (2) the "Interrupted Stays" Rule – that reduce payments to co-located LTCHs when certain thresholds are exceeded.

The 25% Threshold Rule limits the proportion of patients that an LTCH admits from its co-located hospital during the LTCH's cost reporting period.[5] Medicare payments for stays above the threshold are subject to adjustments

1 In 2011, CMS paid $5.3 billion for services furnished by 455 LTCHs.
2 LTCH services generally include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.
3 "Campus" means the physical area immediately adjacent to the provider's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings; and any other areas that the CMS Regional Office determines (on an individual-case basis) to be part of the provider's campus. 42 C.F.R. § 413.65(a)(2).
4 42 C.F.R. § 412.23(e)(2).
5 42 C.F.R. § 412.534. See also *CMS Medicare Claims Processing Manual*, Pub. 100-04, Ch. 3 § 150.9.1.4.

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that will ultimately reduce the LTCH's reimbursement to the lesser of the LTCH PPS rate or the Inpatient PPS rate of the host hospital

The "Interrupted Stays" Rule applies to interrupted stays that occur between co-located providers (i.e., a LTCH and a SNF). An interrupted stay is when a patient is discharged from an LTCH for treatments and services unavailable at the LTCH and then later readmitted to the same LTCH for further medical treatment. If the patient returns to the LTCH after a specific number of days from the discharge, CMS considers it a new admission rather than an interrupted stay. When this occurs, CMS ordinarily reimburses the LTCH with two Medicare payments – one for the first stay and a separate payment for the subsequent stay rather than the single payment for the interrupted stay. Under the "Interrupted Stays" Rule, if the number of discharges and readmissions between a co-located LTCH and the host provider exceeds 5% of the LTCH's total discharges during a cost reporting period, all excessive discharges and readmissions will be paid as a single discharge regardless of the time spent at the intervening facility.

Based upon a recent study,[6] the OIG found that nearly half of the LTCHs have not properly reported their co-located status to CMS claims processing contractors. Specifically, there were 211 LTCHs the OIG determined to have the co-located status, and the preliminary data analysis showed that 141 (or 67%) are co-located. However, only 44 of these 141 co-located LTCHs notified their claims processing contractor of their co-located status. Consequently, at least 97 (46% of the 211 LTCHs) have not notified their claims processing contractor of their co-located status, and this inaccurate data could result in overpayments if these LTCHs exceeded the threshold for either payment policy.

6 The study was conducted as part of an ongoing study entitled Medicare Payments for Interrupted Stays in Long Term Care Hospitals (OEI-04-12-00490). OIG requested that all CMS claims processing contractors provide data on the co-located status of LTCHs in their respective provider service areas for calendar years 2010 and 2011. OIG then reviewed contractors' responses to determine how many LTCHs had notified the contractors of their co-located status, mapped the geographic locations of 211 LTCHs in relation to those of other providers to independently identify co-located LTCHs, and compared the results to the contractor responses to identify co-located LTCHs that have not notified their claims processing contractors of their status.