PUBLICATION

OIG Determines $4.3 Million Improperly Paid to LTCHs for Interrupted Stays in 2010 and 2011 [Ober|Kaler]

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The OIG issued a report on June 3, 2014 summarizing its findings concerning the vulnerabilities and enforcement of Medicare's interrupted-stay policy for long-term care hospitals (LTCHs). Beneficiaries in LTCHs tend to have more complex medical conditions and, as a result, LTCHs are the most expensive post-acute care setting. In 2010 and 2011, the OIG reported that Medicare paid $10.3 billion to 449 LTCHs for services billed on behalf of about 254,000 beneficiaries.

Beneficiaries admitted into a LTCH may leave and return at a later date. A return to the LTCH results in either an interrupted stay or readmission, depending on how long the beneficiary was away from the LTCH and where the beneficiary received additional services (if any). Medicare's LTCH interrupted-stay policy is intended to save money by treating time spent at an LTCH before and after an interruption as a single stay. The policy does not treat the second portion of the LTCH stay (or the return to the LTCH) as a readmission, which would result in paying for two separate stays and additional Medicare payments. Despite this policy, LTCHs may receive a payment for a second stay if the beneficiary returns to the LTCH after a certain number of days (also known as a fixed-day period) or receives services from multiple facilities before returning.

When a LTCH is co-located with another provider instead of being freestanding, CMS applies a payment adjustment if the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5 percent of the LTCH's total Medicare discharges to that provider during a cost-reporting period. If an LTCH exceeds this threshold, all readmissions from the co-located provider are to be paid for as interrupted stays, regardless of the number of days spent away from the LTCH.

The OIG analyzed approximately 311,000 claims submitted by LTCHs for years 2010 and 2011. The OIG also analyzed intervening facility claims for 2010 and 2011 for beneficiaries who had LTCH stays. For nearly all interruptions and readmissions, the intervening facility was a hospital. OIG analyzed these claims submitted by LTCHs and intervening facilities to identify two types of inappropriate payments:

1. to LTCHs for readmissions after stays at intervening facilities within the fixed-day period (i.e., stays that should have been paid as interruptions rather than readmissions) and
2. to intervening facilities for services provided during 3-day-or-less interruptions (i.e., services that should have been paid for by the LTCH under arrangements rather than paid by CMS to the intervening facility).

In its findings, the OIG identified inappropriate Medicare payments of $4.3 million to LTCHs and intervening facilities for interrupted stays. Medicare paid $3.8 million to LTCHs for readmissions after stays at intervening facilities within the fixed-day period. Medicare also paid approximately $523,000 to intervening facilities for services during interruptions of three days or less.

With regard to co-located LTCHs, the OIG determined that one-third of these LTCHs exceeded the 5-percent readmission threshold, but concluded that CMS lacks information to apply payment adjustments to these LTCHs. The OIG further found that a high number of these co-located LTCHs had not notified the MACs of their co-located status and/or not all MACs monitored the co-located status of LTCHs in their jurisdictions.

In OIG's report, it recommended CMS perform the following:

3. Review existing safeguards to determine whether it needs to take additional action to prevent future inappropriate payments for interrupted stays;
4. Determine the extent to which financial incentives influence LTCH readmission decisions;
5. Develop a system to enforce the 5-percent readmission threshold;
6. Take appropriate action regarding LTCHs with a high number of readmissions immediately after the fixed-day period and LTCHs with a high number of readmissions following multiple short stays at intervening facilities; and
7. Take appropriate action on inappropriate payments for interruptions and overpayments to co-located LTCHs that exceeded the 5-percent readmission threshold.

Ober|Kaler's Comments

The OIG's report, while interesting, may have little immediate impact on LTCHs beyond CMS's possible recovery of overpayments where claims clearly failed to fit within the rules applicable to readmissions and interrupted stays. In responding to the OIG's recommendation regarding the readmission threshold, CMS noted that recent legislation will establish a new LTCH PPS structure beginning October, 2015, with specific clinical criteria for standard payments and “site-neutral” payments for patients who do not meet those criteria. CMS said that it is not certain that the 5 percent readmission threshold will continue under the new system. The agency also noted that, until the new policy is implemented, the current policy will remain in place to address alleged “vulnerabilities.” As to the OIG's other recommendations, CMS stated that it would need to study the OIG's data and engage in further review before taking action.