LTCH Interrupted Stays

**Mary Dalrymple**
Managing Director, LTRAX

**Kristen Smith, MHA, PT**
Senior Consultant, Fleming-AOD
Overview

Objectives

- Review definitions of “interrupted stay” for LTCH CARE data submission and Medicare reimbursement
- Discuss common points of confusion
- Answer frequently asked questions
- Discuss clinical impact of interruptions
- Provide strategies to analyze data and reduce program interruptions and interrupted stays
Interrupted Stay

- A patient is discharged from an LTCH for treatment or services not available in the LTCH and, after a time, returns to the same LTCH for further treatment

May exclude:

- Patients discharged AMA
- Patients discharged home or to the community
Why Interrupted Stays?

LTCH Reimbursement: Prospective Payment System (PPS)

- LTCHs paid for each discharge
- Patient discharged and then returns a short time later would qualify for two payments
- Interrupted stay rules prevent a hospital from getting two payments when, from Medicare’s perspective, the patient was readmitted to continue treatment (not begin treatment)
Payment rules depend on length of interruption:

1. Patient is discharged and readmits to the same LTCH within 3 days
   - Patient may transfer to any destination (including home)
   - Treatment provided outside the LTCH is paid for by the LTCH
   - All Medicare reimbursement goes to the LTCH
   - If the patient undergoes treatment, these days count toward the patient’s LTCH length of stay.
Example 1:

On day 1, an LTCH discharges a patient to a short-stay acute care hospital. On day 2, the STACH discharges the patient home. On day 3, the patient returns to the LTCH, and then the LTCH discharges him 28 days later.

**Reimbursement:** The LTCH is reimbursed once for this stay. The LTCH must reimburse the STACH for the patient’s care in that setting.
Example 2:

On day 1, an LTCH discharges a patient to a skilled nursing facility. On day 2, the SNF transfers her to a short-term acute care hospital for emergency care. On day 3, the LTCH readmits the patient. She is discharged several weeks later.

Reimbursement: The LTCH is reimbursed once for this stay. The LTCH must reimburse the SNF and the STACH for the patient’s care in those settings.
Track patient movements & care during interruptions:

- Treatment implications
- Reimbursement implications
  - Payment may be due to other providers
- Length of stay implications:
  - LOS may be affected depending on transfer / discharge location
  - Anticipate short-stay outlier payments
  - Accurately calculate hospital ALOS
2. Patient is discharged and readmitted to the same LTCH after more than 3 days

- Applies to patients transferred to certain settings and stay for more than 3 days (where discharge is counted as day 1) who return within a fixed period of time
  - **Short-term acute care hospital: 4 to 9 days**
  - Inpatient rehabilitation facility: 4 to 27 days
  - Skilled nursing facility: 4 to 45 days
- Medicare pays the STACH, IRF or SNF separately
- A readmission to the LTCH after the fixed period of time counts as a separate stay, eligible for a separate reimbursement at discharge
- Interruption days do not count toward the patient’s LOS
Example 1:

The LTCH transfers a patient emergently to a short-stay acute care hospital on day 1 for emergency care. On day 5, the patient is transferred back to the LTCH, and then he is discharged from the LTCH several weeks later.

Reimbursement: The LTCH is reimbursed once for the patient’s care. The STACH is reimbursed separately for the emergency care provided outside the LTCH.
Example 2:

The LTCH discharges a patient to a skilled nursing facility on day 1 for rehabilitative care. On day 37, the patient’s condition worsens and she is transferred back to the LTCH. She is discharged from the LTCH several weeks later.

Reimbursement: The LTCH is reimbursed once for the patient’s care. The SNF is reimbursed separately.
Scenarios that do not qualify as interruptions:

- A patient stays longer than the fixed-day period at the transfer destination
- A patient who discharges home for more than 3 days
- A patient is discharged to a facility other than a STACH, IRF or SNF
  - e.g., hospice, long-term care setting
- A patient is discharged to more than one facility
Example 1:

The LTCH discharges a patient to a skilled nursing facility on day 1 for rehabilitative care. On day 37, the patient’s condition worsens and she is transferred to a short-term acute care hospital. On day 39, the patient transfers back to the LTCH. She is discharged from the LTCH several weeks later.

Reimbursement: The LTCH is reimbursed for the first stay. Because the patient went to two destinations before the readmission to the LTCH, the second admission initiates a second stay and will qualify for separate reimbursement.
Example 2:

The LTCH transfers a patient emergently to a short-stay acute care hospital on day 1 for emergency care. On day 5, the patient is transferred to a SNF. On day 6, the patient is readmitted to the LTCH, and then he is discharged from the LTCH several weeks later.

Reimbursement: The LTCH is reimbursed for the patient’s stay prior to the emergency transfer. Because the patient went to two destinations before returning to the LTCH, the readmission begins a new stay eligible for separate reimbursement... even though the patient returned to the LTCH within 9 days.
3-Day Interruption

Track patient movements & care during interruptions:

- Treatment implications
- Reimbursement implications
  - Does a readmission start a new episode of care?
  - LTCH not responsible for treatment at other facilities
  - More than one transfer destination changes reimbursement
- LOS implications
  - LOS will depend on days away
  - Anticipate short-stay outlier payments
  - Accurately calculate hospital LOS
A Medicare PPS stay spans from admission through discharge and ignores any transfers that qualify as an interruption in stay.

vs.

An LTCH CARE stay spans from admission to transfer or discharge if the patient hasn’t returned by day 4.
**Similarity:**
- Counting begins on day 1
- Importance of **day 3**
  - PPS and LTCH CARE interruptions both change at day 3
  - PPS: reimbursement implications
  - LTCH CARE: data submission implications

**Difference:**
- LTCH CARE interruption is specifically “an interruption in a patient’s care given by an LTCH because of the transfer of that patient to another hospital/facility per contractual agreement for services. ... Such an interruption must not exceed 3 calendar days.”
  - Unlike PPS interruptions, transfers home for 3 or fewer days start a new episode of care for LTCH CARE purposes
< 3-Day Interruptions

Reported to CMS

- Planned & Unplanned Discharge Assessments
  - LTRAX **Dischg** Tab
- Did the patient have program interruptions? (A2500)
- How many interruptions? (A2510)
- Start and End Dates for interruptions (A2520)
Data Details

- Voluntary for CMS
  - Highly recommended for LTRAX users due to LOS and PPS implications as described previously
  - Can be entered into LTRAX at any time
- Not reported for Expired Assessments
  - LTRAX users can track interruptions for expired patients; highly recommended, but not reported to CMS
- Interruptions that fall under the definition of transfers “per contractual agreement for services”
3-Day Interruptions

All other cases:

- Submit an LTCH CARE Discharge Assessment for the discharge or transfer
  - May be planned or unplanned
- Submit an LTCH CARE Admission Assessment for the patient’s readmission
- Includes all instances in which the patient is away from the LTCH for 4 or more days
- Includes instances in which the patient is discharged AMA or goes home before returning to the LTCH, regardless of days away
Q: My patient transferred to acute and returned within 6 days. This is an interrupted stay, right?

A: Yes and No.

From a reimbursement perspective, CMS will consider this an interrupted stay and the LTCH will get one reimbursement. From an LTCH CARE Data Set perspective, the hospital should submit an LTCH CARE Discharge Assessment for the transfer to acute and an LTCH CARE Admission Assessment for the patient’s return to the LTCH.
Q: My patient transferred to acute and returned within 2 days. I already submitted the discharge assessment. Help!

A: Call LTRAX.

LTRAX prevents you from submitting a discharge assessment until 3 days after the patient’s discharge date. If you have transmitted a discharge assessment for a patient who returned in 3 or fewer days, call us for an inactivation record. You will be instructed to:

- Submit the inactivation
- Revert the patient’s record from discharge to admission
- Wait for the final discharge

Please do not delete the assessment.
Q: My patient transferred home and returned within 2 days. I don’t need to submit a Discharge Assessment, right?

A: Wrong.

Because your patient was not discharged to a health care facility for services under contract, the LTCH CARE rules require you submit a Discharge Assessment for the discharge home and an Admission Assessment for the patient’s return to the LTCH. The same is true for a patient being readmitted within 3 days after being discharged AMA.
Impact of Interruptions (<3 days)

- **Patient level**
  - Gap in continuity
  - New physician directing their medical care
  - New healthcare team

- **Hospital level**
  - Cost
  - Census
  - Length of stay
  - Throughput
  - Referrals

PATIENT SATISFACTION
Identification and Notification

- **Process**
  - Identify individual(s) responsible
  - Communication
  - Tracking (days)

- **Communication**
  - Morning huddles
  - Rounds

- **Documentation**
  - Location of information
  - Include dates of transfer and return
Program Interruptions: Data Analysis

Use of Information

- High volume of interruptions
  - Reason
  - Source
    - Internal clinical resources and skills
- Planned vs. unplanned interruption
- Timing
- Multiple interruptions
  - Appropriate level of care
  - Adequate information with ongoing clinical needs
Identify Opportunities for Improvement

- Clinical assessment and documentation
  - Pre-admission screening
  - Initial clinical assessments
  - Ongoing assessments
- Communication
- Clinical skills/competencies
- Physician resources
  - Consulting physicians
- Clinical resources
- Protocols
Interrupted Stays (>3 days)

Interrupted stays
- Included in Office of Inspector General’s FY 2013 Work Plan
- Focus on improper payments in CY 2011
- Attention on readmission patterns directly following the interrupted stay periods

30-Day Readmissions
- CMS Quality Reporting Program
- Claim-based measure
- Effective January 2015
- Excludes discharges to short-term acute care
Reducing Readmissions

Data Analysis

- Readmission Rates
  - PEPPER Reports
  - Finance
- Admission diagnosis & readmitting diagnosis
- Discharge destination

Identify Readmission patterns

- Diagnostic categories
- Discharge location
  - SNF versus home
- Internal discharge planning and processes
Reducing Readmissions

Identification
- High readmission risk patient
- Interventions based on risk assessment

Discharge Planning Process
- Care transition team
- Coordination
- Discharge information
- Communication
- Resources
Reducing Readmissions

Follow Up
- Follow-up phone calls
- Care coordinator contact

Education
- Internal
  - Physicians/consultants
  - Clinical
  - Case management
- External
  - Home health agencies
  - Skilled nursing facilities