

Billing

Long Term Care Hospital
Prospective Payment System

Billing Objectives

- Identify LTCH PPS billing effective date
- Identify requirements not affected by LTCH PPS
- Understand applicable acute care hospital PPS requirements
- Introduce new billing requirements
- Understand transition period billing

Implementation Schedule

- The LTCH PPS is effective the first day of the provider's first cost reporting period starting on or after October 1, 2002
 - Once the LTCH PPS is effective for the provider, the LTCH bills Medicare in accordance with:
 - New LTCH PPS billing instructions
 - Existing applicable billing instructions for Acute Care Hospital PPS providers
 - *Many non-PPS requirements are the same as respective Acute Care Hospital PPS requirements*

Implementation Schedule (2)

Examples:

| Cost Report Period Start Date on | New Coding Applicable to Discharges on and after |
|---|---|
| 10/01/02 | 10/01/02 |
| 01/01/03 | 01/01/03 |

Standard Systems Delay

- FI and CWF processing will not be ready until at least January 1, 2003
 - Submit claims with required new coding or hold
 - Actual payments during interim will be made using existing procedures
 - Mass adjustments will be done by FI at a later date
- Providers must comply with HIPAA Administrative Simplification Compliance Act
 - Unless exemption obtained

Billing Requirements Unchanged By The Implementation Of LTCH PPS

Unchanged Requirements

- FI and CWF processing
- Timely filing
- General coding under §3604 CMS Pub.13
- Bill types
 - Some Bill types will be eliminated
- Claim change reason codes
- Most other general coding
 - Including MSP, Ancillaries, LOAs, etc.

Patient Status Codes

- Use accurate discharge codes
 - Codes added in last few years
 - Patient status code 62
 - *Discharged/transferred to an IRF*
 - Patient status code 63
 - *Discharged/transferred to an LTCH*
 - Patient status code 64
 - *Discharged/transferred to a SNF certified under Medicaid, but not Medicare*

Ancillary Services

- Same billing continues to apply under LTCH PPS
- Payment under Medicare Part B when payment cannot be made under Part A
 - Certain medical items and services
 - 121 Type of Bill
 - Traditional revenue codes
 - Appropriate entries in service units and total charges
- Reference Pub.10, Sections 228 and 431

Pre-Admission Services

- Billing rule that applied under prior cost-based reimbursement applies under LTCH PPS
- Pre-admission services within 24 hours prior to the inpatient admission (diagnostic and non-diagnostic)
- References
 - Pub. 10, Section 415.6 and Pub. 13, Section 3626.1

Adapting Existing IPPS Requirements For LTCH PPS

Adapting IPPS Requirements For LTCH PPS

- Many of the requirements for providers excluded from PPS are not same as requirements for IPPS
- LTCH PPS different than both methods
 - Benefit availability impacts
 - Full LTC-DRG payments
 - Short Stay Outlier (SSO) payments

LTR Days - Policy for Use

- If beneficiary does not have enough regular Medicare days to exceed short stay outlier threshold, he/she could use LTR days so that a full LTC-DRG may be generated
- Once LTR days are started,
 - Must continue to use for each remaining day of hospitalization for that episode of care until the patient is discharged
 - Even if no additional payment is generated

Full LTC-DRG vs. Short Stay Outlier

- Full LTC-DRG
 - Patient has enough benefit days to exceed number of days that would categorize case as short stay outlier (exceeds threshold)
- Short stay outlier
 - Patient does **not** have enough benefit days to exceed short stay outlier threshold **or**
 - Patient has enough benefit days, but stay does not exceed short stay outlier threshold

Benefits Needed For Full LTC-DRG Payment

- LOS of stay exceeds short stay outlier threshold and patient has benefits available for each day up through this point
 - Admitted on 11/1; Discharged 11/30 = 29 days
 - ALOS = 12 days; 5/6ths = 10 days
 - 15 Coinsurance, 3 LTR days available
 - Full LTC-DRG since LOS exceeds SSO criteria and patient has enough benefits to exceed SSO
 - 18 days > 10 days

Short Stay Outlier - Example #1

- Occurs if patient is discharged or dies before LOS exceeds SSO criteria
 - Payment made with respect to benefit days available
 - Admitted 10/10; Discharged 10/19 = 9 days
 - ALOS = 12 days; 5/6ths = 10 days
 - 20 Coinsurance, 0 LTR days available
 - SSO since LOS does not exceeds SSO criteria even though patient has benefits available
 - *9 days < 10 days*



Short Stay Outlier - Example #2

- Payment with respect to benefit days available
 - Admitted 10/10; Discharged 10/30 = 20 days
 - ALOS = 12 days; 5/6ths = 10 days
 - 3 Coinsurance, 7 LTR days available
 - SSO since patient does not have enough benefits available to exceed SSO threshold
 - 10 days = 10 days

New Billing Requirements Under LTCH PPS

New Concepts

- One claim per stay
- Interim Billing
- Late Charges
- Split Billing
- Interrupted stays
- Benefit days' relation to payment
- Outliers

Billing Frequency

One Claim Per Stay

- Submit only one claim for an entire inpatient stay
 - Elimination of:
 - Late charge billing on 115 TOB
 - Split billing
 - New rules for:
 - Interim billing
 - Interrupted Stay billing



Interim Billing

- Sequential billing not allowed
 - Non-PIP LTCHs may submit interim bills
 - First claim minimum 60 days on 112 TOB
 - Minimum 60-day increments thereafter on 117 TOB
- Adjust claims crossing transition date



Late Charge And Split Billing

- Late charge billing
 - Not permitted on 115 TOB
 - Use 117 TOB (adjustment)
- Split billing
 - Not required
 - Payment based on discharge
 - Adjust transition claims, do not split bill



Claims Crossing PPS Transition Date

Admissions Prior To Transition

- If one sequential bill processed prior to implementation
 - Adjust 112 to be admit through discharge
- If multiple sequential bills processed prior to implementation
 - Cancel 113s; then adjust 112 to be admit through discharge



Interrupted Stays

Interrupted Stays (2)

- Beneficiary discharged to acute care hospital, IRF, SNF or swing bed and returns within fixed day period
 - One claim is submitted
 - Considered one discharge
 - One payment is made

Fixed-Day Periods

- LOS **within** fixed period
 - Original stay and second stay billed on **one** claim
- LOS **outside** fixed period
 - Original stay and second stay billed on **two** separate claims

| Facility Type | Days |
|--------------------|-----------|
| Inpatient Hospital | ≤ 9 |
| IRF | ≤ 27 |
| SNF / Swing Bed | ≤ 45 |



Example #1-A

- Example of patient who meets the last day of fixed day period criteria in interrupted stay policy for acute care hospital discharges
 - Patient admitted to LTCH on 10/05/02 and discharged to acute care hospital on 10/10/02. Day count of interruption begins on 10/10/02 and patient would have to return by 9th day after discharge which is 10/18/02

Example #2-A

- Example of patient who meets the last day of fixed day period criteria in interrupted stay policy for IRF discharges
 - Patient admitted to LTCH on 10/05/02 and discharged to IRF on 11/30/02. Day count of interruption begins on 11/30/02 and patient would have to return by 27th day after discharge which is 12/26/02

Example #3-A

- Example of patient who meets the last day of fixed day period criteria in interrupted stay policy for SNF discharges
 - Patient admitted to LTCH on 10/05/02 and discharged to SNF on 10/10/02. Day count of interruption begins on 10/10/02 and patient would have to return by 45th day after discharge which is 11/23/02

Multiple Interrupted Stays

- Each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility
- If interrupted stay criteria is met, entered as one claim
 - Represented with multiple occurrence span codes of 74

Situations That Are Not Interrupted Stays

- In following situations, second stay is a new admission and billed as such
 - LOS at receiving site exceeds fixed day periods of time
 - Receiving site is not an acute care hospital, IRF, SNF or swing bed
 - Patient admitted to more than one facility or goes home before returning to the LTCH

LTCH LOS Determines Payment Policy

- LTCH payment policy determined by total number of covered days prior to and after interrupted stay
 - First date of discharge = Start of interruption
 - Date of readmission to LTCH = benefit day

LTCH LOS Determines Payment Policy Payment

- Determined at final discharge
 - Full LTC-DRG or SSO
 - High cost outlier may apply
- Payment to receiving site of interrupted stay made separately

Submitting Interrupted Stay Claims To Medicare

- LTCH **may** hold submission of claim for discharges until fixed-day period elapses
 - If patient returns within fixed-day period, submit both stays on one bill

OR

- LTCH **may** submit claim for discharges to applicable facilities
 - If patient returns within fixed-day period, submit adjustment bill

Interrupted Stay Claims And CWF

- Once standard systems updated to accommodate LTCH PPS billing and payment, CWF will edit
 - Claims that should have been billed as interrupted stay claims but were not
 - Claims that were billed as interrupted stay claims but should not have been

Occurrence Span Code 74 And Accommodation Revenue Codes

Occurrence Span Code 74 and Revenue Code 018X

- Use for billing interrupted stays
- Continue to use codes in same manner
 - Occurrence span code 74
 - From date = date of discharge
 - Through date = last date patient not present at midnight
 - Accommodation revenue code 018X
 - Number of days within the 74 span code
- Neither needed for one-day interrupted stays

Example #1-B Acute Care Hospital Discharge

| Admission to LTCH | Discharge to Acute Care Hospital | Return No Later Than |
|--------------------------|---|-----------------------------|
| 10/05/02 | 10/10/02 | 10/18/02 |

- Occurrence span code
74 = 10/10/02 to 10/17/02
- Accommodation revenue code
018X = 8 units

Example #2-B IRF Discharge

| Admission to LTCH | Discharge to IRF | Return No Later Than |
|------------------------------|-------------------------|---------------------------------|
| 10/05/02 | 11/30/02 | 12/26/02 |

- Occurrence span code
74 = 11/30/02 to 12/25/02
- Accommodation revenue code
018X = 26 units

Example #3-B SNF Discharge

| Admission to LTCH | Discharge to SNF | Return No Later Than |
|--------------------------|-------------------------|-----------------------------|
| 10/05/02 | 10/10/02 | 11/23/02 |

- Occurrence span code
74 = 10/10/02 to 11/22/02
- Accommodation revenue code
018X = 44 units

Interrupted Stay Of One Day

- Example:
 - Patient admitted to LTCH on 11/02/02
 - Discharged to acute care hospital on 11/10/02
 - Returns to LTCH by midnight on 11/10/02
- Does meet criteria of interrupted stay
- Occurrence span code 74 and accommodation revenue code 018X are not required on the claim

Basic UB-92 Coding For Interrupted Stays

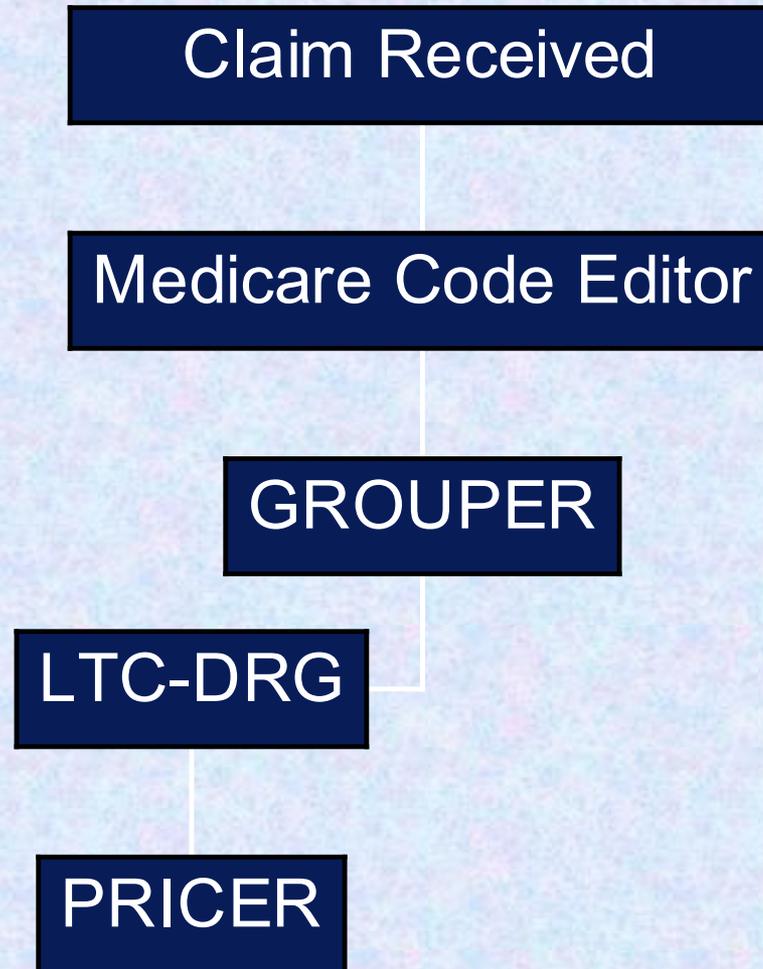
- Payable days in covered field
- Interrupted days in noncovered days field
- Applicable patient status code for discharge
- Occurrence span code 74 with dates of interruption
- Accommodation revenue code 018X
- Other coding as required
 - Ancillary revenue codes and charges

Interrupted Stay Claim Examples

Refer to Training Guide for
Example 1c through 3c

Patient Classification

LTC-DRG Processing



Diagnosis And Procedure Codes

- Use of these codes is not new billing requirement
- Placement of these codes has not changed
- Along with other factors, the codes now determine payment for claim under LTCH PPS
 - Accurate payment is dependent upon coding accuracy

Changes To Processed LTC-DRGs

- Allowed a maximum 60 days after initial assignment to request review by FI
 - Can submit additional information
- FI recommends or denies change
 - If recommended, FI refers claim to QIO



Furnishing Services Directly Or Under Arrangement

- The LTC-DRG payment is payment in full for all covered inpatient hospital services
 - Additional services billable to Medicare Carrier:
 - Physicians' services
 - Physician assistance services
 - Nurse practitioners
 - Clinical nurse specialists
 - Certified nurse midwife
 - Qualified psychologist services
 - Anesthetist Services

Benefits Exhausted During Stay



Benefits Exhaust During Stay - Utilization

- If exhausted during short stay outlier period
 - LTCH receives short stay outlier payment for number of benefit days available
 - FI applies benefits exhaust (BE) date, determines benefit application and reflects days after BE as non-covered

Benefits Exhaust During Stay – Utilization (2)

- If exhausted after short stay outlier threshold is exceeded
 - Full LTC-DRG payable
 - IPPS rules apply
 - FI applies benefits exhaust date, determines benefit application and reflects any applicable span code 70*

Benefits Exhaust Date And Span Code 70

- A3, B3 or C3
 - Indicates last date for which benefits are available for insurance listed in FL 50, Line A, B or C respectively
- Occurrence span code 70
 - Applicable for non-utilization dates as identified

Coding Benefits Exhaust During Stay

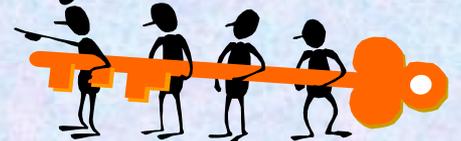
- Use type of bill 11X
- Report covered and non-covered days, as usual
- Report accommodation revenue code(s) and ancillary charges with respective covered and non-covered units and charges
- Remainder of claim coded using existing requirements

Claim Examples - See Training Guide

- Assumptions:
 - High cost outlier threshold amount = \$50,000
 - Threshold amount reached on the 25th day
 - DRG ALOS = 12 days
 - Short stay outlier threshold equals 10 days
 - Billed charges
 - \$3,000 per day for the first 12 days, \$2,000 on the 13th day and \$1,000 each day thereafter
 - Beneficiary elects to use available LTR days

High Cost Outliers

- Outlier period
 - Begins day after the day accumulated covered charges reach outlier threshold amount
- Outlier threshold =
LTC-DRG payment + fixed loss amount
(\$24,450)
- Outlier payment only made for medically necessary days for which beneficiary has benefits available



Coding High Cost Outliers

- If benefits exhausted during stay, also report days and charges for which there are no benefits available
 - FI determines if enough benefit days for each medically necessary day in outlier period
 - If enough, FI makes payment
 - If not enough, FI returns claim with threshold amount
 - LTCH adds daily covered charges until day threshold amount met and reports that date in occurrence code 47

Claim Examples - See Training Guide (2)

- Assumptions:
 - High cost outlier threshold amount = \$50,000
 - Threshold amount reached on the 25th day
 - DRG ALOS = 12 days
 - Short stay outlier threshold equals 10 days
 - Billed charges
 - \$3,000 per day for the first 12 days, \$2,000 on the 13th day and \$1,000 each day thereafter
 - Beneficiary elects to use available LTR days

Benefits Exhaust Prior To Stay And Other No-Pay Bills

- No benefits remaining at admission
 - At covered level of care
- Claim submitted to document continuation of benefit period
 - Use TOB 11X
 - Report all non-covered days
 - Report any services that cannot be billed under Part B benefit with 12X TOB

No-Payment Bills

- Submit when no benefits remain for a covered level of care to document benefit period continuation
 - Use 11X bill type
 - Submit single bill for entire stay upon discharge or death
 - Report all non-covered days
 - Report any services that cannot be billed under Part B on 12X

Billing - Summary

- Use new coding at transition
- LTCHs only paid for covered days
- One claim for entire inpatient stay including interrupted stays
 - Interim billing similar to acute care hospital PPS
 - Stays crossing transition may need cancels and/or adjustments
 - Interrupted stays
- High cost outlier claims