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Long-Term Care Hospital Prospective Payment System

LTCH PPS

Training Guide

PREPARED BY

EMPIRE MEDICARE SERVICES

This Training Guide was developed by Empire Medicare Services for the Centers for Medicare and Medicaid Services. It has been prepared to assist providers and Medicare fiscal intermediaries (FIs) learn the information they will need to know in order to successfully implement updates to the payment system. This training publication was produced incorporating the best information available at the time of publication. Please refer to the final rule as published in the *Federal Register* for authoritative guidance in the system. This publication should not be considered an authoritative source in making Medicare Program policy determinations.

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Using This Training Guide

This training guide has been formatted to highlight key concepts and critical information.

This training guide is divided into four chapters: *LTCH PPS Overview*, *Payment*, *Clinical Issues* and *Billing*. Although each chapter builds upon the previous chapter, each is also comprehensive enough to use for focused training if used in conjunction with the *LTCH PPS Overview* chapter. This manual has been designed to assist providers in the basic understanding of the Medicare Long-Term Care Hospital Prospective Payment System (LTCH PPS) program and implementation. Providers will receive information on the LTCH PPS components, important changes, and potential additional resources.

This training guide will ease the reader through the LTCH PPS using headings and icons to organize and highlight key concepts.

ICON KEY

	Interesting Fact
	Key to success
	Make a note of this
	Examples
	Internet Reference
	This may change on a yearly basis

Throughout the manual you will encounter icons that will assist learners in their pursuit of understanding, as well as aid them in quickly finding reference points in the future.

Acronyms List

Commonly used acronyms in the LTCH PPS Final Rule and their corresponding terms are outlined below.

ALOS	Average length of stay
APR-DRGs	All patient-defined, diagnosis-related groups
BBA	Balanced Budget Act of 1997, Public Law 105-33
BBRA	Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106-113
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106-554
CCR	Cost-to-charge ratio
CFR	Code of Federal Regulations
CMGs	Case-mix groups
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services, formerly HCFA (Health Care Financing Administration)
COLA	Cost of living adjustment
CWF	Common Working File
DRGs	Diagnosis-related groups
DSH	Disproportionate share
FI	Fiscal Intermediary
FY	Federal fiscal year
HCRIS	Hospital Cost Report Information System
HHA	Home health agency

INTRODUCTION TO LTCH PPS

HIPAA	Health Insurance Portability and Accountability Act, Public Law 104-191
ICD-9-CM	International Classification of Diseases 9 th Revision
ICF	Intermediate care facility
IME	Indirect medical education
IPPS	Inpatient acute care hospital Prospective Payment System
IRF	Inpatient rehabilitation facility
LTC-DRG	Long-term care diagnosis-related group
LTCH	Long-term care hospital
MCE	Medicare Code Editor
MDC	Major diagnostic category
MDCN	Medicare Data Collection Network
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review file
MSP	Medicare Secondary Payer
OSCAR	Online Survey Certification and Reporting (System)
PCA	Progressive corrective action
PIP	Periodic interim payment
ProPAC	Prospective Payment Assessment Commission
PSC	Patient status code
QIO	Quality Improvement Organization (formerly Peer Review Organization (PRO))
SNF	Skilled nursing facility

INTRODUCTION TO LTCH PPS

TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248
UHDDS	Uniform Hospital Discharge Data Set

Definitions

Commonly used terms in the LTCH PPS Final Rule and their corresponding terms have been defined below:

Discharged	A Medicare patient in a long-term care hospital is considered discharged when the patient is formally released or the patient dies in the long-term care facility. For payment purposes, discharge occurs when Medicare days are exhausted.
LTC – DRG	The diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes
Hospital-Within-A-Hospital	Part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.
High Cost Outlier Payment	An additional payment beyond the standard Federal prospective payment for cases with unusually high costs
Satellite Provider	A hospital-within-a-hospital type facility that is owned by separate, existing LTCH.
Short-stay Outlier	A case that has a length of stay between one day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped.

LTCH PPS Overview

Highlights of the LTCH PPS

Objective

This section provides participants with background information on long-term care hospital (LTCH) classification and an overview of the prospective payment system for Medicare payment of inpatient hospital services provided by a long-term care hospital. It also introduces terminology and concepts that will facilitate understanding of the detailed discussions in later sections.

Participants will learn about the following information in the course of this chapter:

The statutory basis for the implementation of the Long-term Care Hospital Prospective Payment System.

Which hospitals are and are not impacted by the implementation.

A high-level understanding of the LTCH PPS components and how they interrelate.

Background

LTCHs are certified under Medicare as short-term, acute-care hospitals which have been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under § 1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay of greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

Statutory Basis

Section 123 of Public Law 106-113, the Balanced Budget Refinement Act of 1999 (BBRA), as amended by section 307 of Public Law 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), mandates that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002, to replace the reasonable cost-based payment system mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Affected Medicare Providers

LTCHs are certified under Medicare as short-term acute-care hospitals and, for the purpose of payment, are defined as having an average inpatient length of stay of greater than 25 days.



Provider Number Range

By statute, there are no LTCH units; however, there are satellite and hospital-within-hospital LTCHs that are co-located with acute-care hospitals and other Medicare providers. LTCHs are identified by the last four digits of the Medicare provider number, which range between “2000” and “2299.”

OVERVIEW

Hospitals Not Affected

The following hospitals are paid under special payment provisions and, therefore, will not be subject to the LTCH prospective payment system rules:

Veterans Administration hospitals

Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403

Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act)

- Two of the four Maryland LTCHs included on CMS's OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and are therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center (#212005) and Deaton Hospital and Medical Center (now known as University Specialty Hospital, #212007).

Foreign hospitals, which will continue to have payment made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c)

Nonparticipating hospitals

New Average Length of Stay Criteria

LTCH's Average Length of Stay

For cost reporting periods beginning on or after October 1, 2002, the LTCH average length of stay is based on the hospital's Medicare inpatients' total days medically necessary days (**covered and noncovered days**). Previously all days for both Medicare and non-Medicare patients were used to determine the hospital's average length of stay. CMS has changed its methodology for determining the average inpatient length of stay to exclude non-Medicare patients. However, it is not changing the methodology for counting both covered and noncovered Medicare days when calculating whether the LTCH meets the 25-day average length of stay.



CMS has directed FIs to determine whether existing LTCHs qualify for payments under the LTCH PPS according to the revised criteria after October 1, 2002. In addition, CMS has directed FIs to notify LTCHs about whether an LTCH qualifies for payment under the LTCH prospective payment system before the start of the LTCH's next cost reporting period. FIs will continue to monitor compliance with the new requirements.



Related Statutory Citations

CMS changed the methodology for determining the average length of stay for purposes of section 1886(d)(1)(B)(iv)(I) of the Act, but is not changing the methodology for purposes of section 1886(d)(1)(B)(iv)(II) of the Act (Sec. 412.23(e)). For purposes of the latter provision (subclause (II)), CMS is retaining the current methodology (which includes non-Medicare as well as Medicare patients) because it believes that the considerations underlying the change in methodology for subclause (I) are not present under subclause (II).

New Long-Term Care Hospitals

A new LTCH is a hospital that has its first cost reporting period as an LTCH beginning on or after October 1, 2002. It also must not have received payment as an LTCH for discharges occurring prior to October 1, 2002 under present or previous ownership (or both).

Payment Provisions Under LTCH PPS

The BBRA of 1999 as amended by the BIPA of 2000 authorizes the establishment of payment rates under a PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case level, in order to ensure that payment most accurately reflects cost.

LTCH PPS applies to inpatient hospital services furnished by Medicare-participating entities that have been excluded from the acute care hospital inpatient prospective payment system as LTCHs.

Prior to October 1, 2002, each LTCH was paid on a hospital-specific basis under the TEFRA system. When the PPS is totally phased-in, after the five-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a **Federal payment rate**.

The per discharge Federal rates under the prospective payment system will be based on average LTCH costs in a base year updated for inflation to the first effective period of the system. The prospective payment system will be updated annually as is done with the inpatient, IRF and SNF/Swing bed PPS systems.

Payment under LTCH PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular Long-Term Care Diagnosis Related Group (LTC-DRG), the relative weight of the LTC-DRG and Federal payment rate.

Periodic Interim Payment

LTCHs may elect to be paid using the periodic interim payment (PIP) method described in §413.64(h), and may be eligible to receive accelerated payments as described in §413.64(g).

Patient Classification System

In general, a case will be grouped based on the clinical characteristics of the Medicare beneficiary. These patient classification system groupings are called LTC-DRGs. The LTC-DRGs are based on the existing DRGs used in the IPPS.

Patient discharges will be grouped using ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, up to six procedures performed during the stay, age, sex and the discharge status of the patient. The same GROUPER software developed for the inpatient PPS will be used, but with LTCH-specific relative weights. For fiscal year (FY) 2003, Version 20 hospital inpatient PPS GROUPER will be used.

Relative Weights

Payment weights assigning a specific value representing the relative resource use of each LTC-DRG have been determined by the “hospital-specific relative value method.” This methodology normalizes charges within each hospital and then compares them across hospitals. These relative weights will be updated annually using the most recent available claims data.

Payment Rate

Payments to LTCHs under the LTCH PPS will be based on a single standard Federal rate for both the inpatient operating and capital-related costs, but not certain pass-through costs. The FY 2003 LTCH PPS standard Federal rate is \$34,956.15. This single standard Federal rate will be updated annually by the excluded hospital with capital market basket index.

Payment Adjustments

The LTCH PPS does not include any of the following “typical” adjustments to the standard Federal rate found in other prospective payment systems: rural location, geographic reclassification, disproportionate share (DSH) or indirect medical education (IME).

The LTCH PPS does include some other typical adjustments to reflect differences in area wages. The standard Federal rate will also be adjusted by a cost-of-living adjustment (**COLA**) for LTCHs located in Alaska and Hawaii.

Additional payments will be also made for high cost outlier cases that exceed the outlier threshold (LTC-DRG payment + fixed-loss amount).

Case-Level Adjustments

Payments to LTCHs are based on the LTC-DRG as well as adjustments specific to the case. Unlike IRF PPS, there are no special payment policies for transfer cases or deaths. Therefore, if a patient in LTCH “A” is discharged and then admitted to LTCH “B,” each LTCH will receive a separate LTC-DRG payment based on the number of days the patient is in the respective LTCH.

However, CMS has established payment categories for certain cases that have stays of considerably less time than the average length of stay, known as “short-stay outliers.” In addition, there are special payment policies for cases defined as “interrupted stays” and “high cost outliers.”

There are also special payment policies for LTCHs that are co-located with other Medicare providers.

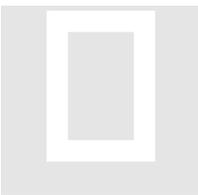
Short-Stay Outliers

Short-stay outliers have stays of considerably less than the average length of stay. The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment. A short-stay outlier is a case that has a length of stay less than or equal to 5/6 of the average length of stay (ALOS) for the LTC-DRG to which the case is grouped. A short-stay outlier will be paid the least of:

120 percent of the cost of the case,

120 percent of the LTC-DRG specific per diem payment, or

The full LTC-DRG payment.



Example

If the ALOS for a particular LTC-DRG is 30 days, then the short-stay outlier policy would apply to any stays that are 25 days or less in length. (5/6 of 30 days is 25 days)

OVERVIEW

Interrupted Stays

An interrupted stay is a case in which an LTCH patient is discharged and then admitted directly to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed and then returns to the same LTCH within a fixed period of time. The fixed period of time for each provider type is as follows:

Acute care hospital – 9 days or less

Inpatient rehabilitation facility (IRF) – 27 days or less

Skilled nursing facility (SNF) – 45 days or less

Swing-bed hospital – 45 days or less

If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time prior to returning to the LTCH, it is an interrupted stay. An interrupted stay is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made.

Short-stay outliers are also eligible for high cost outlier payments if their costs exceed the outlier threshold.

High Cost Outliers

Additional payments will be made for those cases that are high cost outliers; that is, they have unusually high costs. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold. The outlier threshold is the LTC-DRG payment plus a fixed-loss amount. The fixed-loss amount is determined such that projected outlier payments are equal to eight percent of total LTCH PPS payments. The fixed-loss amount for FY 2003 is \$24,450.

High cost outlier cases will be paid 80 percent of costs above the outlier threshold.

Facility-Level Adjustments

Facility-level adjustments are based on individual LTCH characteristics.

Area Wage Adjustment

The LTCH PPS will include an area wage adjustment that will be phased in over five years. The wage adjustment will be made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value. For fiscal year (FY) 2003, the labor-related share of the standard Federal rate is 72.885 percent.

COLA

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the hospital inpatient PPS). For FY 2003, the nonlabor-related share of the standard Federal rate is 27.115 percent.

Other Facility-Level Adjustments

Based on analyses of patient charge data from FYs 2000 and 2001, MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there was no empirical evidence to support other adjustments. Therefore, there will be no adjustment for DSH, IME, or geographic reclassification.

Co-Located Providers

There is a special payment policy for Medicare providers that have the same location or that are on the same campus as an LTCH. Co-located providers include hospitals within hospitals, satellite facilities, and on-site SNFs/swing beds.

If the rate of discharges and readmissions between the LTCH and a co-located acute hospital exceeds five percent, only one LTC-DRG will be made to the LTCH for all such discharges and readmissions during that cost reporting period. If an LTCH is co-located with other Medicare providers, there is an additional five percent threshold for all such discharges and readmissions to the LTCH.



LTCHs must inform their FIs of co-located facilities and payment reconciliation will occur at the end of the cost report period. LTCHs will be required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that begins on or after October 1, 2002. A change in co-located status must also be reported to the FIs within 60 days of such event.

Budget Neutrality and Offset to Payments

Total payments under LTCH PPS must equal the amount that would have been paid if the PPS had not been implemented. A reduction factor applies to all Medicare LTCH payments during the transition to the LTCH PPS to account for several factors. This transition to the “full” Federal payment rate will be described in additional detail in *Chapter 2—Payment*.

Implementation Phase-in

The PPS for LTCHs will be phased in over five years from cost-based reimbursement to Federal prospective payment. During this period, payment is based on an increasing percentage of the LTCH payment and a decreasing percentage of its cost-based reimbursement rate for each discharge. LTCHs may exercise a one-time, irrevocable opportunity to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment.

Beneficiary Liability

Beneficiary liability will operate the same as under the previous cost-based, TEFRA payment system. Therefore, even if Medicare payments are below the cost of care for a patient, the patient cannot be billed for the difference in any case where a full LTC-DRG payment is made.

Generally, beneficiaries may be charged only for deductibles, coinsurance and noncovered services (telephone and television for example) for days where there is Medicare coverage. Beneficiaries (or their Medigap insurance) are responsible for all noncovered days as described below:

Once a stay triggers a full LTC-DRG (i.e., it exceeds the short stay outlier threshold), Medicare will pay for the entire stay up to the high cost outlier threshold regardless of patient coverage. However, Medicare will only pay for covered days for lengths of stays that are within the short stay outlier policy.



When an LTCH receives less than the full LTC-DRG payment, as in the case of the short-stay outlier, beneficiaries may also be charged for items and services provided during the stay that were not the basis for the short-stay payment.

To reiterate, **beneficiaries may not be charged for the differences** between the hospital's cost of providing covered care and the Medicare LTCH prospective payment amount for the full LTC-DRG.

The policy for use of lifetime reserve days (LTR) will be discussed in the Payment and in the Billing chapters.

Billing Changes

LTCHs will continue to use most of the same billing principles and practices. However, billing under LTCH PPS introduces the new concept of billing “one claim for an entire” stay. Within this concept, providers will learn that when late charges will be submitted through an adjustment, split billing has been eliminated, claims must include any incurred “interrupted stay” and that only non-PIP providers may submit interim bills. Several claim examples reflecting possible billing situations will be reviewed in *Chapter 4—Billing*.

Processing Between October 1, 2002 and January 1, 2003:

Currently, there are edits in place that prohibit the submission of claims that span an LTCH's fiscal year start date. These edits require the hospital to split the bill over the cost report begin date. Until LTCH PPS systems changes are in place, LTCHs must continue to split their bills if there are patients in the LTCH when the LTCH transitions over to PPS. Once the changes are implemented, pre-PPS bills must be cancelled and the entire stay should be re-billed under PPS.

Correct Coding

Correct ICD-9-CM diagnosis and procedure coding by the LTCH is very important as these codes play a role, along with other factors, in the way in which a Medicare claim is paid. In *Chapter 3—Clinical Issues*, we will review this issue as well as provide information on Medicare requirements and coverage criteria for inpatient hospital services related to LTCH PPS.

Processing Bills Between October 1, 2002 and the Implementation Date

All applicable LTCH PPS coding must be used by LTCH providers with cost reporting periods beginning on or after October 1, 2002. However, CMS will not have the standard computer systems changes necessary to accommodate claims processing and payment under the LTCH PPS in place before January 1, 2003. Claims submitted prior to implementation will be processed under the reasonable cost-based payment methodology. On or after January 1, 2003, those processed claims will be mass-adjusted by the FI to reflect the PPS payment methodology.

Beginning October 16, 2002, all LTCHs will also be required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding.



Medical Review

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicated LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule. In such case, the days of a stay failing medical review will be excluded from the qualification computation for the LTCH's cost reporting period.

LTCH PPS Payment

Payment concepts and examples

Objective

The objective of the Payment chapter is to provide information that is needed to understand and compute the payment due to Medicare providers under the Prospective Payment System for Long-Term Care Hospitals (LTCH PPS).

Participants will learn about the following information in the course of this chapter:

The LTCH PPS will be phased in over a five-year transition period from cost-based reimbursement to prospective payment.

Patient classification system utilizing ICD-9-CM codes will assign a Long-Term Care diagnosis-related group (LTC-DRG) based on date of discharge.

Payment rates will be based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services).

Certain pass-through costs (i.e., bad debts, indirect medical education and blood clotting factors) are not included in LTCH payment rates.

Background

The LTCH PPS replaces the existing reasonable cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) payment system under which LTCHs are currently paid.

LTCHs are certified under Medicare as short-term acute-care hospitals which have been excluded from the hospital inpatient PPS under § 1886(d)(1)(B)(iv) of the Social Security Act, and for the purpose of Medicare payment are defined as having an average inpatient length of stay of greater than 25 days.

Statutory Requirements

The BBRA of 1999, as amended by BIPA of 2000, mandates that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for **cost reporting periods** beginning on or after **October 1, 2002**, to replace the reasonable cost-based TEFRA payment system.

LTCHs Defined

Long-Term Care Hospitals (LTCHs) that are subject to the requirements of the LTCH PPS meet all of the following criteria:

- They are certified under Medicare as short-term acute-care hospitals, which have been excluded from the inpatient acute care hospital prospective payment system (IPPS).
- They meet state licensure requirements for acute care hospitals under section 1886(d)(B)(iv) of the Social Security Act.
- They are not excluded LTCH units in a facility, although they can be a satellite and/or hospital-within-a-hospital, co-located within another facility.
- LTCHs are identified by the last four digits of the Medicare provider number, which range between “2000” and “2299.”
- They have a provider agreement with Medicare in order to receive Medicare payment.
- They have an average length of stay for Medicare patients of greater than 25 days. or
- The hospital has been exempted from certain of these general LTCH requirements by §1886(d)(1)(B)(iv)(II) of the Social Security Act (implemented by 42 CFR §412.23(e)).

LTCH PPS PAYMENT

Hospitals Not Subject to LTCH PPS

Some hospitals are paid under special payment provisions and are therefore not subject to LTCH PPS.

The following hospitals are paid under special payment provisions and, therefore, **will not be subject to the LTCH PPS rules:**

- Veterans Administration hospitals
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act)
- Two of the four Maryland LTCHs included on CMS's OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore are not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center (#212005) and Deaton Hospital and Medical Center (now know as University Specialty Hospital, #212007).
- Foreign hospitals, which will continue to have payment, made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c).
- Nonparticipating hospitals

Average Length of Stay

The methodology for determining ALOS at an LTCH is **changed**.

LTCHs are certified under Medicare as short-term acute-care hospitals and, for the purpose of payment, are defined as having an average inpatient length of stay of greater than 25 days.

CMS has changed its methodology for determining the average inpatient length of stay to exclude non-Medicare patients. However, it is not changing the methodology for counting both covered and noncovered Medicare days when calculating whether the LTCH meets the 25-day average length of stay.

For cost reporting periods beginning on or after October 1, 2002, the LTCH average length of stay is based on the hospital's Medicare inpatients' total medically necessary days, which will include Medicare covered and Medicare noncovered days.

Previously all days for both Medicare and non-Medicare were used to determine the hospital's average length of stay. The revised criteria will be in effect for LTCHs for their first cost reporting period that begins on or after October 1, 2002 using the same procedures employed by the FI under the previous payment system.

Qualifying LTCHs Under PPS for ALOS

For cost reporting periods beginning on or after October 1, 2002, LTCHs must meet this revised qualification established under the LTCH PPS that counts only Medicare patients in the average 25-day ALOS calculation. Only hospitals qualifying as LTCHs under revised criteria will be subject to LTCH PPS for their first cost reporting period that begins on or after October 1, 2002.



Fiscal Intermediaries (FIs) must determine whether existing LTCHs qualify for payments under LTCH PPS according to revised criteria after October 1, 2002. The FI will review the LTCH's discharge data from its most recent cost reporting period to determine if it satisfies the new criteria. If the FI determines that the LTCH will not qualify, FIs will follow procedures already established in section 3001.4 of CMS Pub. 15-1. Further instructions will be forthcoming.

FIs must notify LTCHs whether the LTCH qualifies for payment under the LTCH PPS before the start of the LTCH's next cost reporting period. Each LTCH will undergo an ongoing monitoring and notification by FIs regarding compliance with the 25-day ALOS.

Medical Necessity and the LTCH's ALOS

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review

LTCH PPS PAYMENT

procedure established under the final rule. In such case, the **days of a stay failing medical review will be excluded from the provider's 25-day average length of stay computation** for the LTCH's cost reporting period.

Determining and Maintaining LTCH Status

Ordinarily, the determination regarding a hospital's average length of stay is based on the hospital's most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six-month period are used. (See CMS Pub. 15-1, PRM 1, 3001.4)

Payment Provisions of the LTCH PPS

Note:

BIPA confers broad authority to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, in order to ensure that payment most accurately reflects cost

LTCH PPS applies to inpatient hospital services (operating and capital) furnished by Medicare participating entities that have been excluded from the acute care hospital inpatient prospective payment system (IPPS) as LTCHs.

Medicare Part A costs not paid for under the LTCH PPS are subject to the interim payment provisions. Examples of these costs include:

Medicare costs of an approved medical education program,

Bad debts,

Blood clotting factors,

Anesthesia services by hospital-employed non-physician anesthetists or obtained under arrangement, and

Costs of photocopying and mailing medical records requested by a QIO/PRO.

Prior to October 1, 2002, each LTCH was paid on a hospital-specific basis under the TEFRA system. When PPS is totally phased-in, after the five-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a “standard Federal rate.”

A Medicare patient in a long-term care hospital is considered discharged when:

For purposes of the long-term care hospital qualification calculation, as described in Sec. 412.23(e)(3), the patient is formally released;

For purposes of payment, as described in Sec. 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

The patient dies in the long-term care facility.

Budget Neutrality

Total payments under LTCH PPS must equal the amount that would have been paid if the PPS had not been implemented. The standard Federal rate was determined based upon this statutory requirement. In addition, behavioral changes following implementation of the LTCH PPS were taken into account.

The budget neutrality offset for FY 2003 is 0.934.

An additional offset is based on payment calculations related to actuarial estimates of the number of LTCHs that will elect to be paid blended payments vs. 100 percent Federal prospective payments will be applied to each Medicare payment.



The reduction factor for LTCH payments during the transition period accounts for the monetary effect of the five-year transition from the present cost-based payment system to LTCH PPS including the fact that a certain number of LTCHs will opt for an irrevocable election to be paid 100 percent under the LTCH PPS.

For LTCHs paid under the transition blend methodology (discussed in the Facility-Level Adjustments section), the budget neutrality offset will be applied to **both** the reasonable cost-based TEFRA rate percentage and the Federal rate percentage.

The offset will also be applied to all payments to LTCHs electing payment under 100 percent of the Federal rate.

The budget neutrality offset equals one minus the ratio of the estimated TEFRA reasonable cost-based payments (that would have been made had the LTCH PPS not been implemented) to the projected total Medicare program payments that would be made under the transition methodology including the option to elect payment based on 100 percent of the Federal rate.

The budget neutrality offset for FY 2003 is 0.934. That is, **all** LTCH PPS payments in FY 2003 will be reduced by 6.6 percent.

An unadjusted Federal PPS rate is the product of the LTC-DRG relative weight and the standard Federal rate.

Calculating an Unadjusted LTCH Prospective Payment Rate

Payment under the LTCH PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular Long-Term Care Diagnosis Related Group (LTC-DRG), the weight of the LTC-DRG and Federal payment rate. These factors are used to calculate an unadjusted LTCH PPS rate. An unadjusted Federal PPS rate is the product of the LTC-DRG relative weight and the standard Federal rate.

Patient Classification System

The BBRA required the use of diagnosis-related groups (DRGs) for patient classification purposes in the PPS for LTCHs.

Cases are generally grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings or **LTC-DRGs** are based on the existing the Case Mixed Groups (CMGs) and DRGs used in the IPPS.

LTCH patient discharges will be grouped using:

ICD-9-CM codes based on the principal diagnosis,

Up to eight additional diagnoses, and

Up to six procedures performed during the stay, as well as

Age,

Sex, and

Discharge status of the patient.

GROUPER

LTCH PPS will use the same GROUPER software developed by 3M for the IPPS for FY 2003 (currently Version 20.0), but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

Relative weights will be updated annually using the most recent available LTCH claims data.



LTCH PPS PAYMENT



PRICER

LTC-DRG relative weights and the geometric average lengths of stay are maintained in the LTCH PRICER program. Payment for short-stay outliers is also determined in the PRICER logic. This program calculates the Medicare payment rate using the following data:

LTC-DRG assignment made by the GROUPER

- Standard Federal rate
- Applicable facility-level adjustments
- Applicable case-level adjustments
- The applicable five-year phase-in period blending ratio for those providers that choose to be paid on the blended rate.

Payment for interrupted stay cases will be handled with billing instructions, not PRICER. Payments based on the co-located policy will be determined at cost-report settlement.

PRICER Inputs

Provider Specific File Data (§3656.3 and §3850 of the MIM); Fields-3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19 (five-year blend or may choose 100%), Fields 21*, 22, 25 (although this field refers to the operating cost/charge ratio, for LTCH, data entered here will be a combined operating and capital cost/charge ratio.)

Provider #	Length of Stay (LOS)
Patient Status	Covered Days
Covered Charges	Lifetime Reserve Days (LTR)
Discharge Date	DRG (from Grouper)

* Field 21 refers to facility-specific rate and will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS was not being implemented.

LTCH PPS PAYMENT

PRICER Outputs

PPS Return Code	Regular Days Used
MSA	LTR Days Used
Wage Index	Blend Year, 1-5
Average LOS	Outlier Threshold
Relative Weight	DRG
Final Payment Amount	COLA
DRG Adjusted Payment Amount	New facility- specific rate
Federal Payment Amount	Calculation Version Code
Outlier Payment Amount	National Labor Percent
Payment Amount	National Non-Labor Percent
Facility Costs	Standard Federal Rate
LOS	Budget Neutral Rate

Relative Weights

Payment weights assigning a specific value representing the relative resource use of each LTC-DRG were determined by the "hospital-specific relative value method."

This methodology normalizes charges within each hospital and then compares them across hospitals.

Relative weights will be updated annually using the most recent available claims data.

Payment Rate

There is a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors).

The FY 2003 LTCH PPS the standard Federal rate, prior to facility-level adjustments, is **\$34,956.15**.

The standard Federal rate will be updated annually by the excluded hospital with capital market basket index.

The formula for computing an unadjusted LTCH PPS prospective payment is:

$$\text{Unadjusted Federal Prospective Payment} = \text{LTC-DRG Relative Weight} * \text{Standard Federal Rate}$$

LTCH PPS Payment Adjustments

Payments will be based on the LTC-DRG assigned as well as possible adjustments specific to the case and/or the facility.

LTCHs are distinguished from other inpatient hospital settings by serving patients that require an average length of stay of greater than 25 days, thus case-level adjustments for certain cases that have stays of considerably less than the average length of stay were established.

More than one case-level adjustment may apply to the same case.

Case-level adjustments established in the LTCH PPS include:

Short-stay outliers

Interrupted stays

High cost outlier cases (i.e., that exceed the outlier threshold)



Note

Unlike IRF PPS, there is **no** special payment policy for transfer cases or deaths.

The LTCH PPS also includes several **facility-level adjustments**. The facility-level adjustments include adjustments for:

The area wage index

The cost of living adjustment (COLA) for LTCHs in Alaska and Hawaii

There is also a payment policy for LTCHs co-located with other Medicare providers.

The **LTCH PPS does not include** any of the following “typical” adjustments found in other prospective payment systems:

Rural location

Geographic reclassification

Disproportionate Share (DSH)

Indirect Medical Education (IME)

Short-Stay Outliers

CMS has established payment categories for certain cases that have stays of considerably less time than the average length of stay, known as “short-stay outliers.” The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment.



Definition

A short-stay outlier is a case that has a length of stay **between one day and up to and including 5/6** of the average length of stay for the LTC-DRG to which the case is grouped.

Payments for short-stay outliers are determined in the PRICER logic.

A short-stay outlier case is paid the least of:

The **full** LTC-DRG payment;

120 percent of the LTC-DRG specific **per diem** payment. (The per diem amount for short-stay outliers for each LTC-DRG is calculated by dividing the full LTC-DRG payment by the average length of stay for the LTC-DRG, and multiplying by the length of stay of the case.

120 percent of the **cost** of the case (determined using the hospital-specific cost-to-charge ratio (CCR)).



Short Stay Outlier Computation Example

Use this background information to follow the short stay outlier computation example which follows.

The patient was in the LTCH for **10 days** (LOS). Upon discharge the patient had incurred \$13,870.33 in charges and the services provider were grouped to LTC-DRG 113.

The relative weight of LTC-DRG 113 is relative weight is 1.4103 and the average length of stay (ALOS) for LTC-DRG 113 is 36.9.

The provider’s cost-to-charge-ratio (CCR) is 0.8114 and is located in an MSA, which has a 1/5 wage index of 1.0301.

LTCH PPS PAYMENT

To Compute the Full LTC-DRG Payment:

((Standard Federal Rate x Labor percentage) x (1/5 Wage Index Value) + Non-labor Share) x LTC-DRG Weight

$$\begin{aligned}
 & \$34,956.15 \text{ (standard Federal rate)} \\
 & \times 0.72885 \text{ (labor \%)} \\
 & \$25,477.79 \text{ (labor share)} \\
 & \times 1.0301 \text{ (1/5 wage index value)} \\
 & \$26,244.67 \text{ (wage adjusted labor share)} \\
 & + 9,478.36 \text{ (non-labor share} = \$34,956 \times 0.27115) \\
 & \$35,723.03 \text{ (adjusted standard Federal rate)} \\
 & \times 1.4103 \text{ (LTC-DRG 113 relative weight)} \\
 & \hline
 & \mathbf{\$50,380.19 \text{ (Full LTC-DRG payment)}}
 \end{aligned}$$

To Compute 120% of the Specific LTC-DRG Per Diem:

$\frac{\text{Full LTC-DRG Payment}}{\text{ALOS LTC-DRG}} \times \text{LOS of the case} \times 1.2$

$$\begin{aligned}
 & \frac{\$50,380.19 \text{ (full LTC-DRG payment as calculated above)}}{36.9 \text{ (ALOS LTC-DRG 113)}} = \$1,365.32
 \end{aligned}$$

Short Stay Outlier Example Resolution:

In the example, the case would be paid 120% of cost (\$13,505.27) since it is less than \$120% of the specific LTC-DRG per diem (\$16,383.80) and the full LTC-DRG payment (\$50,380.19).

$$\begin{aligned}
 & \$1,365.32 \\
 & \times 10 \text{ (LOS)} \\
 & \$13,653.20 \\
 & \times 1.2 \\
 & \hline
 & \mathbf{\$16,383.80 \text{ (120\% of per diem)}}
 \end{aligned}$$

To Compute 120% of Cost:

Charges x CCR = Cost

$$(\$13,870.33) \times (0.8114) = \$11,254.39$$

$$\mathbf{120\% \text{ of cost} = \$11,254.39 \times 1.2 = \$13,505.27}$$

Interrupted Stays

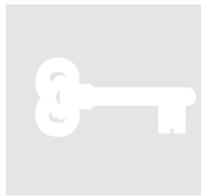
An interrupted stay is defined as a case in which an LTCH patient is admitted upon discharge to an inpatient acute care hospital, or inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed hospital and returns to the same LTCH within a specified period of time.

Acute care hospital = **9 days or less**

Inpatient Rehabilitation Facility (IRF) = **27 days or less**

Skilled Nursing Facility (SNF) = **45 days or less**

Swing-bed hospital = **45 days or less**



If the length of stay at the receiving provider is equal to or less than applicable fixed period of time, it is considered to be an interrupted stay case and is therefore treated as a single (one) discharge for the purposes of payment.

Only one LTCH PPS payment will be made.

Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions. It is possible that a beneficiary's stay at an LTCH may be interrupted multiple times. Each interrupted period that occurs should be evaluated individually regarding the number of days at the intervening facility to determine if it meets the requirements of the interrupted stay policy. Any interrupted period that meets the interrupted stay policy requirements should be entered as one claim, but represented with multiple occurrence span codes of 74.

Three common situations **do not meet** the definition of an interrupted stay under LTCH PPS:

1. Length of stay at “receiving” site of care exceeds the above listed fixed periods of time; the return to the LTCH will be a **new “admission.”**
- For example, patient is discharged from the LTCH and then admitted to an acute hospital. The patient then returns to the same LTCH in 10, 11, 12 or more days. The return to the LTCH will be a new admission and billed as such.
2. “Receiving” site of care is not an acute care hospital, an IRF or a SNF/swing bed; the return to the LTCH will be a **new “admission.”**

- For example, patient is discharged from the LTCH and then admitted to care provided by an HHA; any return to the LTCH will be a new admission and billed as such.
3. Patient is admitted to more than one facility or goes home between LTCH stays; the return to the LTCH will be a *new admission*.
- For example, if the patient is discharged from the LTCH, admitted to an IRF, and then the IRF discharges the patient to an acute care hospital and finally, the acute care hospital discharges the patient to the original LTCH, the return to the LTCH will be a new admission and billed as such.

In all three of these situations, which **do not meet the definition of an interrupted stay**, the original discharge from the LTCH to the other provider will be treated as a discharge for payment purposes. The second stay at the LTCH will also be treated as a discharge for payment purposes. **Therefore, two separate payments will be made to the LTCH.**

If the length of stay at the receiving provider falls within the fixed periods of time **and** the Medicare beneficiary did not either go home or to yet another facility before returning to the LTCH:

The original stay and the second stay that occurs upon the return to the LTCH should be billed to Medicare on one claim.

The claim must reflect the interrupted period of time.

The first bill should be cancelled if it has already been submitted and processed.

<p>Note: An interrupted stay at an LTCH can also be a short-stay outlier.</p>	<p>If length of stay at the receiving provider falls outside the fixed periods of time or the Medicare beneficiary did go home or to a third facility before returning to the LTCH:</p> <p>The original stay and the second stay that occurs upon the return to the LTCH are separate, in other words, not interrupted. Therefore, two separate claims should be submitted.</p>
--	--

For the percentage of payments that will be made under the TEFRA system during the blended payments of the five-year transition to the standard Federal payment rate, the FI will treat each segment of the interrupted stay as a separate discharge. (FIs should follow the same procedure as under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

The following examples illustrate several scenarios related to interrupted stays.

**Example #1-A:**

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to an acute care hospital on October 10, 2002.

Day count of the interruption begins on October 10, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the ninth day after discharge, which is October 18, 2002.

The patient's stay at the LTCH may be paid as a short-stay outlier since it was only five days prior to the discharge.

If it is an interrupted stay and the stay following the readmission to the LTCH is greater than 5/6 of the ALOS for the LTC-DRG, then the stay will generate a full LTC-DRG payment.

**Example #2-A:**

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to an IRF on November 30, 2002.

The day count of the interruption begins on November 30, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 27th day after discharge, which is by December 26, 2002.

**Example #3-A:**

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to a SNF on October 10, 2002.

The day count of the interruption begins on October 10, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 45th day after discharge, which is November 23, 2002.

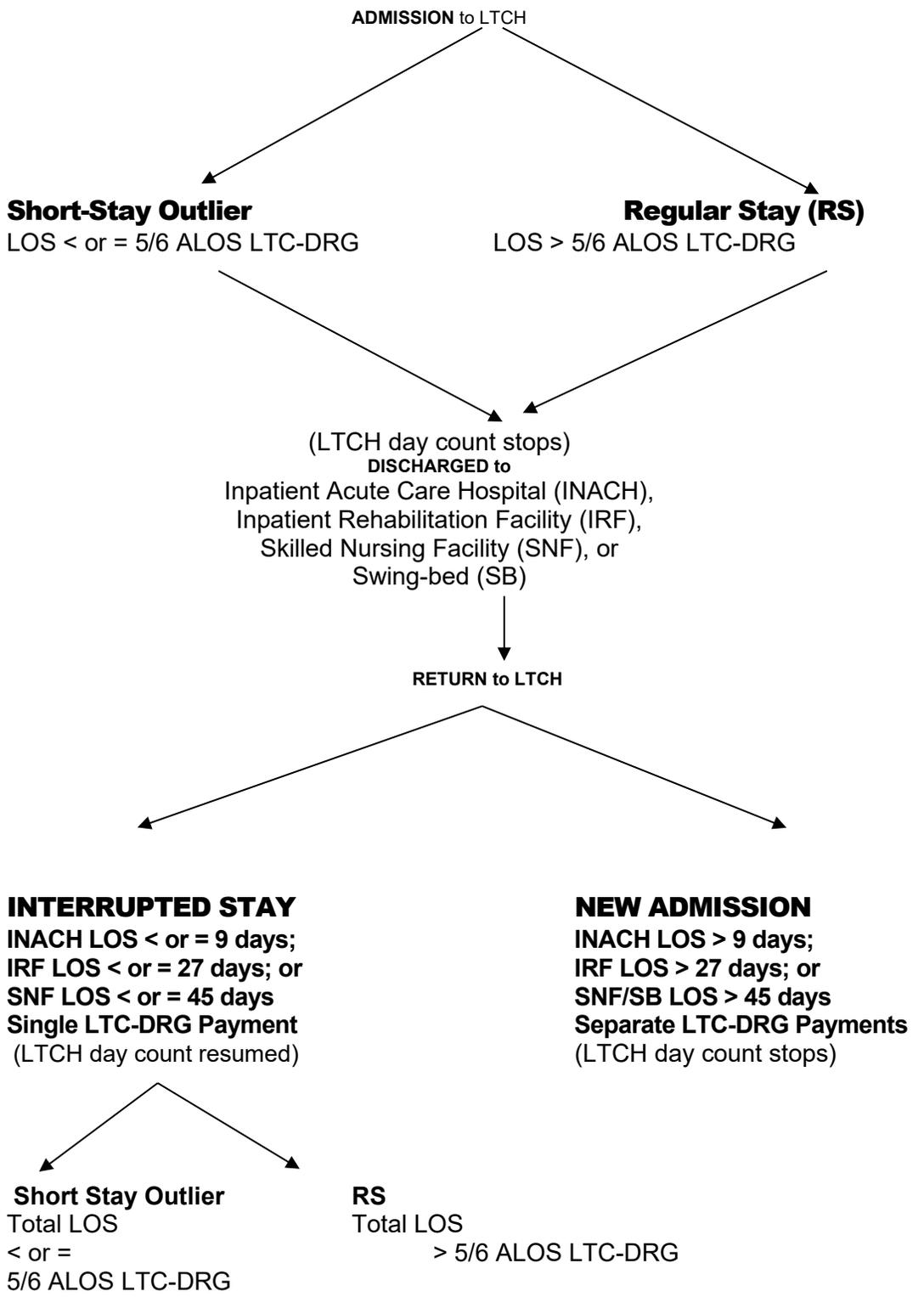
Payment Determination

Payments for short-stay outliers are determined in the PRICER logic.

Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. The flow chart on the next page describes the order that will be used to assess whether or not the adjustments apply. For example, a case may be a short-stay outlier and also be an interrupted stay.

SHORT-STAY OUTLIERS AND INTERRUPTED STAYS



High Cost Outlier Cases



Additional payments will be made for high cost outlier cases. These are cases that exceed the high cost outlier threshold.

High Cost Outlier Threshold

The high cost outlier threshold is the LTC-DRG payment plus the current fixed-loss amount. If the estimated cost of the case is greater than the high cost outlier threshold an additional payment will be added to the LTC-DRG payment amount.

$$\text{High Cost Outlier Threshold} = \text{LTC-DRG Payment} + \text{Fixed-loss Amount}$$

Fixed-loss Amount

The fixed-loss amount is determined such that projected outlier payments are equal to eight percent of total Federal LTCH PPS payments. The FY 2003 fixed-loss amount is \$24,450.

High Cost Outlier Payment

The high cost outlier payment will be 80 percent of the difference between the estimated cost of the case and the high cost outlier threshold.

$$\text{High Cost Outlier Payment} = 80\% * (\text{Estimated Cost of Case} - \text{High Cost Outlier Threshold})$$

Estimated Cost of Case

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio (CCR) obtained from the latest settled cost report.

$$\text{Estimated Cost of Case} = \text{Medicare Allowable Charge} * \text{LTCH CCR}$$

Note

No retroactive adjustments will be made to payments for high-cost outliers to account for changes in LTCHs hospital-specific cost-to-charge ratios.

Determining the Cost-to-Charge Ratio

This section describes the appropriate data sources for computing an overall Medicare hospital-specific cost-to-charge ratio for the purpose of determining short-stay outlier

payments at §412.529 and high cost outlier payments at §412.525(a) under the LTCH PPS.



FIs will use the latest available settled cost report and associated data in determining each LTCH's overall Medicare cost-to-charge ratio. The FI will then calculate updated ratios each time a subsequent cost report settlement is made.

As discussed in the August 30, 2002 final rule (67 FR 56026), retrospective adjustments to the data used in determining outlier payments will not be made.

The LTCH PPS payment includes operating and capital-related costs and excludes the costs of bad debts, medical education, nurse anesthetist, and blood clotting factors, which are paid for on a reasonable cost basis.

Total Medicare Charges

Total Medicare charges for LTCHs will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital).

Total Medicare Costs

Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only.

For LTCHs, overall Medicare cost-to-charge ratios will be based on the latest settled cost report data unless such data are either unavailable or outside the ranges noted below.

Use the appropriate urban or rural statewide operating and capital average.

New Providers or Unreasonable Value

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period.

If the overall Medicare cost-to-charge ratio cannot be calculated (i.e., “new” LTCHs) or is not reasonable, the appropriate urban or rural statewide operating and capital average calculated annually by CMS under the IPPS and published in the *Federal Register* should be summed and used.

For FY 2003, the statewide average operating and capital cost-to-charge ratios can be found in Tables 8A and 8B of the August 1, 2002 Hospital Inpatient PPS final rule (67 FR 50263).

For “new” LTCHs, use the IPPS statewide averages until the LTCH’s actual cost-to-charge ratio can be computed using the first settled cost report data, which will then be used for the subsequent cost reporting period. As stated above, when the statewide average cost-to-charge ratios are used, the LTCH’s cost-to-charge ratio will not be retrospectively adjusted based on later data.

Equitable Distribution of Outlier Payments

To ensure that the distribution of outlier payments remains equitable, an LTCH’s overall Medicare cost-to-charge ratio is **considered not to be reasonable** if the value exceeds the combined (operating plus capital) upper (ceiling) and lower (floor) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the *Federal Register*.



For FY 2003, the combined operating and capital upper limit is 1.421 (1.258 plus 0.163) and the combined operating and capital lower limit is 0.206 (0.194 plus 0.012) (see August 1, 2002, 67 FR 50125). If the overall Medicare cost-to-charge ratio appears not to be reasonable, the fiscal intermediary should ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average.

Provider Specific File

The Provider Specific File contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the LTCH PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for LTCHs will be entered on the provider specific file only in Field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

Calculating the Cost-to-Charge Ratio

Under the LTCH PPS, an overall Medicare CCR is calculated as follows: Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). Total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101). Divide the Medicare costs by the Medicare charges to compute an overall Medicare cost-to-charge ratio.

CCR= Medicare Costs÷Medicare Covered Charges

Facility-Level Adjustments

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "...appropriate adjustments to the long-term hospital payment system..."



Variables examined for use included an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME). There was no empirical evidence to indicate the need for rural location, the geographic reclassification, DSH or IME adjustments.

Wage Adjustment

The system will include an area wage adjustment that will be phased in over five years. The wage adjustment will be made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.

Wage Adjustment = Labor-Related Share of Standard Federal Rate * Wage Index Value

The wage index is being phased-in over five years.

Wage Index

The standard Federal rate is adjusted for differences in area wages by multiplying the labor-related share by the applicable wage index value based on the physical location of the LTCH (i.e., no reclassification). For FY 2003, the labor-related share is **72.885 percent**.

For FY 2003 the applicable wage index value is 1/5 the value of the pre-reclassification (no floor) hospital inpatient wage index without regards to reclassification.

COLA

The standard Federal rate will also be adjusted by a cost-of-living adjustment (**COLA**) for LTCHs located in Alaska and Hawaii by multiplying the non-labor-related portion of the standard Federal rate by the applicable COLA factor from the Office of Personnel Management based on the county in which the LTCH is located. For FY 2003, the non-labor-related share is **27.115 percent**.

For FY 2003, the COLA factors are:

AREA	COLA
Alaska:	
All areas	1.25
Hawaii:	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawaco County	1.2375

Only one LTC-DRG payment will be made to the LTCH for all such discharges during that cost reporting period once the threshold has been reached.

Co-located Providers:

There is a special payment policy for co-located providers. CMS established this policy to discourage patient-shifting among Medicare Providers that share a physical location.

A co-located LTCH is a long-term care hospital that occupies space in a building used by another provider, or in one or more entire buildings on the same campus of buildings used by another provider. An LTCH may be free standing and there may be other Medicare providers with that LTCH as either satellite facilities or hospitals-within-hospitals. The LTCH itself may also be a satellite facility or a hospital-within-a-hospital.

Hospital-Within-A-Hospital

Definition

A hospital-within-a-hospital is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

An LTCH that exists as a hospital-within-a-hospital, that is, it shares space with a separate acute care hospital, is considered co-located with that acute care hospital, as are on-site rehabilitation and psychiatric hospitals or units, swing-beds or skilled nursing facilities (SNFs).

A hospital-within-a-hospital must meet the criteria at CFR 412.22 (e) to qualify for exclusion from the IPPS unless it is exempted in CFR 412.22 (f) which is basically a 'grandfathering clause' for hospitals exempted from IPPS on or before September 30, 1995.

CFR § 412.22 (e) Criteria

To be exempt from IPPS, a hospital-within-a-hospital must:

Have a separate governing body, chief executive officer, chief medical officer, and medical staff and meet one of the following criteria:

1. Perform basic functions independently from the host hospital,
2. Incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located, **or**
3. Have an inpatient load of which at least 75 percent of patients are admitted from sources other than the host hospital.

Satellite LTCH Provider

Definition

Satellite providers are a hospital-within-a-hospital type facility that is owned by separate, existing LTCH.

LTCHs have established satellites that share space in a building or on a campus occupied by another hospital in order to establish additional locations that are an excluded hospital (specifically an LTCH). These additional LTCH locations may be either freestanding hospitals or hospitals-within--hospitals.

For these providers to be excluded from the acute care hospital PPS, a LTCH satellite must meet all the criteria in CFR §412.22(h).



Given these requirements, providers will need to maintain separate utilization statistics for the satellite. This does not mean that the numbers cannot be combined for cost reporting and billing, but the beds, days, and discharges for patients treated in the satellite have to be tracked separately in a way that can be verified by audit, to comply with the satellite rules.

CFR §412.22(h) Criteria

To be excluded from IPPS, a satellite of a hospital must:

1. Must maintain admission and discharge records that are separately identified from those of the hospital in which it is located;
2. Cannot commingle beds with beds of the hospital in which it is located;
3. Must be serviced by the same fiscal intermediary as the hospital of which it is a part;
4. Must be treated as a separate cost center of the hospital of which it is a part;
5. For cost reporting purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation,
6. Must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as that hospital,
7. Must independently comply with the qualifying criteria for exclusion from the acute care hospital inpatient prospective payment system; and
8. The total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital that was excluded from the acute care hospital inpatient prospective payment system for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period rehabilitation needs.
9. For cost reporting periods beginning on or after October 1, 2002, a satellite facility may not be under the authority or control of the

governing body or chief executive officer of the hospital in which it is located.

10. Furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.



Co-location and Provider Numbers

An LTCH satellite facility has the **same** provider number as it's controlling hospital but different from the hospital in which it is located.

A hospital-within-a-hospital has a **separate** provider number from its host hospital, but in fact may actually exist as one or more floors within the host building.

Co-location Payment Policy



If the rate of discharges and readmissions between the LTCH and a co-located provider exceeds five percent, only one LTC-DRG will be payable to the LTCH for all such discharges and readmissions during that cost reporting period. There are two distinct five percent thresholds:

ON-SITE ACUTE CARE HOSPITAL:

If during a cost reporting period an LTCH readmits more than five percent of its patients who were discharged to an onsite acute care hospital, only one LTCH-DRG payment would be made to the LTCH for all such discharges and re-admittances during that cost reporting period once the threshold has been reached.

ON-SITE SNF, SWING-BED, IRF OR PSYCHIATRIC FACILITY:

If during a cost reporting period more than (a separate) five percent of the LTCH patients are discharged to an on-site SNF, swing-bed, IRF, or psychiatric facility and then readmitted to the LTCH, only one LTC-DRG payment would be made to the LTCH for all such discharges during that cost reporting period once the threshold has been reached.

Prior to exceeding any of these five percent thresholds, discharges from and readmissions to LTCHs will be evaluated under the interrupted stay policy. Payments under this policy will be determined at cost report settlement. Further instructions will be forthcoming.

Notify Your FI Regarding Co-location Status



LTCHs will be required to notify their FIs and CMS regional office about the providers with which they are co-located within 60 days of their first cost reporting period that begins on or after October 1, 2002.

Changes in co-located status must also be reported to the FIs within 60 days of such events. The implementation of the on-site policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs will notify the CMS Regional Office of such arrangements.

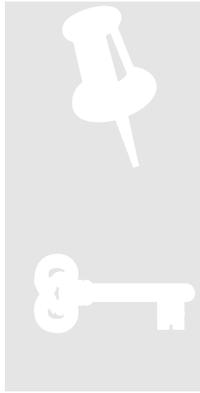
Transitioning to the Federal Rate

LTCH PPS will gradually change from a blend of payments under the TEFRA system and the Federal rate to a full 100 percent Federal per-discharge LTC-DRG based prospective payment.

LTCH PPS will be phased in over a **five-year transition period** from cost-based reimbursement to Federal prospective payment, based on their cost reporting period beginning on or after October 1, 2002.

Payment is based on an increasing percentage of the LTCH payment and a decreasing percentage of its cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	LTCH PPS Federal Rate Percentage	TEFRA Rate Percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0



LTCHs are allowed a one-time irrevocable opportunity to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment.

To exercise this option, for cost reporting periods beginning on or after **October 1, 2002 and before December 1, 2002**, the LTCH must notify its FI of this election in writing. The notification must and be received by the FI no later than November 1, 2002.

To exercise this option, for cost reporting periods beginning on or after **December 1, 2002**, the LTCH must notify its FI in writing 30 days prior to the start of the LTCH's next cost reporting period.

New LTCH Providers and the Transition Period

A new LTCH is defined as a hospital that has its first cost reporting period as an LTCH beginning on or after October 1, 2002.

New LTCHs will not be eligible for the blended transition payments; new LTCHs will be paid based on 100 percent of the Federal rate.

Note:

Under the BIPA, during cost reporting periods beginning during FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the cost reimbursed portion of transition payments.

Periodic Interim Payment (PIP)

LTCHs may elect to be paid using the periodic interim payment (PIP) method described in CFR Part 42 §413.64(h), and may be eligible to receive accelerated payments as described in §413.64(g).

LTCHs that choose not to elect to receive PIP payments or those who are not qualified to receive PIP payments may continue to bill on an interim basis (see *Chapter 4—Billing* for more detail).

The PIP amount is based on the transition blend for those LTCHs that elect to be paid during the five-year transition based on the blended transition methodology for cost reporting periods beginning on or after October 1, 2002.

The PIP amount is based on the estimated prospective payment for the year rather than on the estimated cost reimbursement for those LTCH providers who are paid based on 100 percent of the standard Federal rate.

Please Note:

Outlier payments that are payable upon submission of a discharge bill are not included in the PIP amounts.

Beneficiary Liability

Beneficiary liability will operate generally the same as under the previous TEFRA payment system. Once a stay triggers a full LTC-DRG payment, the beneficiary cannot be billed for the difference between Medicare payments and the cost of care, even if the Medicare payment is below the cost of care.

Beneficiaries (or their Medigap insurance) are still responsible for all noncovered days. This is the same policy as exists under the previous TEFRA system.

Beneficiaries may only be charged for:

Deductibles

Coinsurance (days 61-90)

Lifetime reserve days coinsurance

Noncovered services (i.e., telephone and television, etc.)

Services furnished and not covered under Medicare due to benefits being exhausted or no entitlement to Part A

Beneficiaries can also be charged when an LTCH receives less than the full LTC-DRG payment as in the case of a short-stay outlier.

Provider can charge the beneficiary for:

- Deductible
- Coinsurance (days 61-90)
- Lifetime reserve days coinsurance
- Any items and services provided during stay not covered on the basis of the short-stay outlier payment



Sample Scenarios - Full LTC-DRG:

Once a stay triggers a full LTC-DRG payment (i.e., it exceeds the short-stay outlier threshold described later), Medicare will pay for the entire stay up to the high cost outlier threshold the same way it as it does under the IPPS, regardless of patient coverage. **However**, Medicare will pay only for covered days for lengths of stay equal to or below 5/6 of the average length of stay for a specific LTC-DRG.

For an LTC-DRG where the ALOS is 30, 25 days (5/6 of 30) would be the short-stay outlier threshold. If a patient's stay is 25 days or less, Medicare will pay it as a short-stay outlier. So, if for example, a patient has only 15 remaining days of Medicare coverage

and stays 24 days in the LTCH, Medicare will only pay for 15 days. However, if the patient has 27 days remaining, a full LTC-DRG will be payable since the stay has exceeded the short-stay outlier threshold and now will generate a full LTC-DRG payment which will constitute Medicare payment until and unless it becomes a high cost outlier. See Table 2.1 for illustration of this and other examples.

Once the beneficiary's stay reaches the 5/6 short-stay outlier threshold and receives the full LTC-DRG payment, consistent with IPPS, the remaining "inlier" days of the stay (and associated charges) are considered covered until the high cost outlier is reached even though the beneficiary is not using any Medicare covered days. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the lifetime reserve (LTR) days.

Using Lifetime Reserve Days

In the case of a stay that is categorized as a short-stay outlier for payment purposes (because the patient has run out of regular benefit days prior to exceeding the short-stay outlier threshold of 5/6 of the ALOS for the specific LTC-DRG), the remaining days of the patient's stay will be counted towards the beneficiary's lifetime reserve days (in the absence of an election not to use them) for the remainder of the episode of care, that is, until either the patient is discharged or the lifetime reserve days are exhausted.

Once a beneficiary starts using lifetime reserve days, each remaining day of hospitalization for that episode of care will be counted against those reserve days, even if no additional Medicare payments are generated until the high cost outlier threshold is reached.

High Cost Outlier Benefit Days

Consistent with the policy under IPPS, Medicare will pay for high cost outlier payments only for covered days, that is, days for which the beneficiary has either regular benefit days or lifetime reserve days for the period (or portion) of the stay beyond the high cost outlier threshold.

Sample Scenarios – LTR Days

Beneficiary “A” is admitted to the LTCH with 26 remaining days of regular Medicare coverage and is grouped to an LTC-DRG with an ALOS of 30 days. “A” has sufficient regular benefit days to trigger a full LTC-DRG payment (5/6 of the ALOS for that LTC-DRG) for this stay without going into lifetime reserve days. “A” would only need to consider using lifetime reserve days should the stay become a high cost outlier.

Beneficiary “B” is grouped to the same LTC-DRG as “A” but has only 10 remaining days of regular Medicare coverage. Lifetime reserve days will be used for the entire remainder of the stay (unless “B” elects not to use them and to otherwise assume responsibility for payments) and the day count will continue, uninterrupted, until the patient is either discharged or the days are exhausted.



Table 2.1 Beneficiary Liability Scenarios

<i>ALOS of LTC-DRG</i>	<i>Short Stay Outlier Threshold (5/6 of ALOS)</i>	<i>Actual Length of Stay</i>	<i>Payable as Short Stay Outlier</i>	<i>Benefit Days Available (Full/Co/LTR)</i>	<i>LTR Used Assuming patient elects to use if needed.</i>	<i>Medicare-Payable Days</i>
30	25	25	Yes	0/15/30	10	25
30	25	20	Yes	0/15/30	5	20
30	25	27	No	0/15/30	12	27
30	25	29	No	0/25/30	4	29
30 Beneficiary “A”	25	35	No	0/26/30	0	35
30	25	45	No	0/26/30	0	45
30 Beneficiary “B”	25	35	No	0/10/30	25	35

Part B Ancillary Services Payment Under LTCH PPS

Current payment methodology continues to apply for Part B ancillary services.

Remittance Advices

Reason and remark codes already in existence for inpatient hospital PPS will apply under LTCH PPS.

Medicare Summary Notices and Explanation of Medicare Benefits

Existing Medicare Summary Notice messages will be used for LTCH PPS coverage.

Clinical Issues

Coverage, coding, and Medical Review

Objective

The objective of the Clinical Issues chapter is to provide information on Coverage criteria, coding, and medical review related to the prospective payment system for long-term care hospitals (LTCH PPS).

Participants will learn the following by the end of this chapter:

Medicare requirements for inpatient hospital services provided by a long-term care hospital.

The importance of correct ICD-9-CM diagnosis and procedure coding by the long-term care hospital.

Who is responsible for medical review activities for LTCH services.

Impacts of interrupted stays on LTCH medical records systems.

ICD-9-CM coding similarities, differences and areas contractors and/or providers should focus on during and after the implementation of the LTCH PPS.

Background

Clinically related information has not changed with the implementation of the new LTCH prospective payment system, but given the fact that LTCHs are the least understood Medicare provider excluded from payments under the acute care PPS, the following information is being provided.

LTCHs typically furnish extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions.

LTCHs are a heterogeneous (mixed) group of facilities ranging from old tuberculosis and chronic disease hospitals to newer facilities designed primarily to care for ventilator-dependent patients.

Generally, Medicare patients in LTCHs were in an acute care hospital just prior to admission to the LTCH.

LTCHs can offer generalized services. (i.e., chronic disease care and specialized services such as physical rehabilitation or ventilator-dependent care.)

LTCH patients receive a range of acute care hospital and “post-acute care” services, which could include:

- Comprehensive rehabilitation
- Cancer treatment
- Head trauma treatment
- Pain management.

LTCHs must meet several criteria that have clinical implications. LTCHs must:

Meet state licensure requirements for acute care hospitals under section 1886(d)(B)(iv) of the Social Security Act.

Have an average length of stay greater than 25 days.

Have an agreement with the Quality Improvement Organization (QIO) formerly known as the Peer Review Organization (PRO).



Sources and Destinations of LTCH Patients

The vast majority of patients are admitted to an LTCH from an acute care facility with direct admission from the community being second most frequent.

Based on the diagnosis of the patient, discharges vary between Skilled Nursing Facility (SNF), Home Health Agency (HHA), and home.

Please Note:

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicate LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

Specialty Groups of LTCHs by Patient Mix

There is a wide belief that the population of LTCHs is heterogeneous; however, the Centers for Medicare & Medicaid Services (CMS) studies have identified four distinct MDC classifications:

1. Rehabilitation-related services
2. Circulatory problems
3. Mental specialty
4. Multi-specialty

Broad categories of conditions as defined by major diagnostic categories (MDCs) were used to classify LTCHs according to medical conditions of patients. MDCs are the principal diagnostic categorizations used under the inpatient acute care hospital prospective payment system (IPPS).

Most MDCs correspond to a major organ system, though a few correspond to etiology.

LTCH Patient Patterns

Most patients in LTCHs have several diagnosis codes on their Medicare claims. LTCH patients are generally less stable upon admission than patients admitted to other post-acute care facilities.

LTCH Cost and Demographic Patterns

LTCHs have a higher proportion of patient cost associated to ancillary services (i.e., pharmacy, laboratory, and radiology services). They also provide care to a disproportionately large number of Medicare beneficiaries who are eligible because of disability versus age 65 or older.

Patient Classification System

The Balanced Budget Reduction Act, better known as the BBRA, required the use of diagnostic-related groups (DRGs) for patient classification in the PPS for LTCHs.

As a result of the BBRA requirement to use DRGs for patient classification in the PPS for LTCHs, CMS developed a patient classification system called Long-Term Care DRGs (LTC-DRGs). LTC-DRGs, like their IPPS-DRG counterparts, are based on broad categories of conditions as defined by major diagnostic categories or MDCs.

Major Diagnostic Categories

MDCs classify services according to the medical conditions of patients. The MDC is a diagnostic categorization tool. The MDC is the heading under which several DRGs are classified. Each MDC is usually based on a single organ system and in general, a particular medical specialty. For example, diseases of the kidney are not mixed in with (classified with) diseases of the circulatory system (heart and blood vessels).

The principal diagnosis determines MDC assignment. Within all MDCs, cases are divided into surgical and medical DRGs.

Surgical DRGs

Surgical DRGs are assigned to discharges that have a procedure of some significance performed (not EKGs, scans or phlebotomy, etc.). Surgical DRGs are assigned based on surgical hierarchy that orders individual procedures or groups of procedures by resource intensity.

Medical DRGs

Medical DRGs do not have significant procedures performed.

EKG or minor surgical procedures generally not performed in the operating room are considered to be medical DRG rather than surgical DRGs.

Secondary diagnosis, age, sex and discharge status also play an important role in the final LTC-DRG assigned.

Note: 86.11, biopsy of skin and subcutaneous tissue is not considered a surgical DRG.

Long-Term Care Diagnosis Related Groups

LTC-DRGs are based on existing DRGs under the IPPS. As with the IPPS DRGs, assignment of discharges to LTC-DRGs are grouped using ICD-9-CM codes. The LTC-DRGs are weighted to account for the differences in the resources used to treat medically complex LTCH patients. LTCH specific relative weights also account for the fact that LTCHs generally treat multiple medical problems. The LTC-DRG assignment is based on the LTCH discharge date to ensure it appropriately assigned

Assignment of Discharges to LTC-DRGs

Each discharge from an LTCH is assigned only one LTC-DRG.

Patient discharges will be grouped using ICD-9-CM codes based on principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as, age, sex, and discharge status of the patient.

A Medicare patient in a long-term care hospital is considered discharged when:

The patient is formally released (CFR Pat 42 §412.23(e)(3)).

The patient stops receiving Medicare-covered long-term care services (CFR Part 42 §412.521(b)); or

The patient dies in the long-term care facility.



Reference

A list of LTC-DRGs can be found in *Federal Register*/Vol. 67, No. 169/Friday, August 30, 2002/Rules and Regulations, Table 3, starting on page 56076.

Coding and Editing

Diagnostic and procedure information from the patient’s hospital record is reported using ICD-9-CM codes on the uniform billing form currently in use. The ICD-9-CM coding system is the basis for IPPS DRGs and now LTC-DRGs.



Because the assignment of a case to a specific LTC-DRG is the basis for the amount paid for the case, **it is mandatory that ICD-9-CM coding be accurate.**

Medicare Fiscal Intermediaries enter the clinical and demographic information submitted by providers into their claims processing systems and subject it to a front-end automated screening process called the Medicare Code Editor (MCE). The screens identify cases that require further review before assignment into a DRG can be made.

ICD-9-CM Coding System

The ICD-9-CM coding system is the basis for CMS DRGs and now long-term care (LTC) DRGs.



All changes to the ICD-9-CM coding system that affect DRG assignment are addressed annually in the acute care hospital inpatient prospective payment system proposed and final rule.

Approved ICD-9-CM code changes become effective at the beginning of the Federal fiscal year, October 1. Since LTC-DRGs are based on acute care DRGs, the annual acute care changes would affect LTC-DRGs.

LTCHs should **pay special attention to invalid diagnosis codes and invalid procedure codes** located in the annual proposed and final rules of the acute care hospital inpatient prospective payment system.

As changes occur, LTCHs must obtain and correctly use the most current edition of the ICD-9-CM codes.

Claims with invalid ICD-9-CM diagnosis codes will not be processed by the Medicare standard claims processing system.

Please Remember:



Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and affect the facility’s payment.

The emphasis on the need for proper coding cannot be overstated.

HIPAA Compliance

ICD-9-CM coding terminology and the definitions of principal and other diagnoses of the Uniform Hospital Discharge Data Set (UHDDS) are consistent with the

requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(45 CFR part 162).

Principal Diagnosis

The principal diagnosis on a claim determines the Major Diagnostic Category assignment. The following definitions have been approved by the Secretary of Health and Human Services, are requirements of the ICD-9-CM coding system and were used as a standard for the development of CMS DRGs.

Principal Diagnosis Defined:

The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.



Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. The principal diagnosis must remain the same on every bill submitted for the LTCH stay. Normal adjustments will be allowed.

It is important to remember that the appropriate principal diagnosis at the LTCH is **not necessarily the same diagnosis patient received care for at the acute care hospital**. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded both as principal diagnoses and as secondary diagnoses.

Secondary/Other Diagnoses

Secondary Diagnoses Defined:

Other diagnoses, also called secondary diagnoses or additional diagnoses, are defined as all conditions that coexist at the time of admission, that **develop subsequently**, or that affect the treatment received or the length of stay or both.



The concept of capturing diagnoses that develop subsequent to admission is important for data and reimbursement purposes. These additional codes could ultimately change the DRG-LTC to which the stay is assigned.

Any new diagnoses identified subsequent to admission should be reported on the next interim claim and then reported on each and every subsequent adjustment claim through and including the discharge claim.

Procedures

Procedures should be coded based on current ICD-9-CM coding requirements, i.e.; all procedures performed should be reported on the LTCH claim. This includes procedures

LTCH PPS CLINICAL ISSUES

that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

Medicare Code Editor

The MCE identifies cases requiring further review based on the clinical and demographic information on the claim. Cases requiring further review include situations such as:

Improperly coded claims (i.e., hysterectomy for a man);

Surgical procedures not covered by Medicare (i.e., organ transplant in a non-approved facility);

Lack of information on claim (i.e., ICD-9-CM codes are required to be entered at their highest level of specificity but code is reported with less than correct number of bytes). MCE will reject this claim.

Principal diagnosis does not justify admission.

Correct Coding Examples



Principal Diagnosis

The appropriate principal diagnosis for the LTCH is not necessarily the same diagnosis for which the patient received care at the acute care hospital.

Patient is discharged from an acute care facility and admitted to an LTCH.

Patient suffers a stroke (ICD-9-CM category 436, Acute, but ill-defined cerebrovascular disease) – admitted to acute hospital.

Patient is discharged and then admitted to an LTCH for further treatment of left-sided hemiparesis and dysphasia.

The appropriate code from the LTCH would be a code from ICD-9-CM diagnosis code 438 (Late affects of cerebrovascular disease), such as ICD-9-CM diagnosis code 438.20 (Late affects of cerebrovascular disease, hemiplegia affecting unspecified side), or ICD-9-CM diagnosis code 438.12 (Late affects of cerebrovascular disease, dysphasia).

Coding guidelines state that the residual condition is sequenced first followed by the cause of the late effect. In the case of a cerebrovascular disease, the combination code describes both the residual of the stroke (example, speech or language deficits or paralysis), and the cause of the residual (the stroke).

ICD-9-CM diagnosis code 436 would only be used for the first (initial) episode of care for the stroke, the admission to the acute care hospital.

When the patient is admitted to the LTCH, the focus of treatment has shifted from identification and treatment of the acute episode to treatment of the sequelae (follow-up) or residual deficits resulting from the acute disease process.

The principal diagnosis must remain the same throughout the entire stay at the LTCH.

Secondary Diagnoses with No Bearing on LTCH Stay

Secondary diagnoses that have no bearing on the LTCH stay should not be coded.

A patient who has recovered from pneumonia during a previous episode of care would not have a diagnosis code for pneumonia included in the list of discharge diagnoses.

The pneumonia was not treated during the LTCH admission; thus, it has no bearing on the case and **it should not be coded** on the LTCH claim.

Secondary Diagnoses Coded as Conditions Develop

Secondary or additional diagnoses should be coded **as conditions develop**. They should be reported on the next claim and continue to be submitted on all claims including the discharge claim.

A patient develops a decubiti during the LTCH stay.

Decubiti was not present on admission, but **must be added to the next claim**. It must continue to be displayed on each claim thereafter, even if the decubiti is successfully treated and resolved before the patient's discharge from the LTCH.

Procedure Codes Performed in Acute Care Setting

Codes reflecting procedures provided during a previous acute care hospital stay would not be included on the LTCH claim because the procedure was not performed during the LTCH stay.

A patient with several chronic illnesses is admitted to an acute care hospital with a diagnosis of appendicitis; an appendectomy is performed.

Patient is discharge and then admitted to an LTCH for medical treatment following the surgery.

As a result of multiple secondary conditions, the patient needs a higher level of care than could be provided in a SNF or at home by an HHA.

Appendicitis **should not be coded** because the condition was resolved with the removal of the appendix. In other words, the procedure should not be included on the patient's LTCH claim since it was not performed during the LTCH admission.

Procedures Performed in the LTCH

All procedures performed during the LTCH stay must be reported on the claim.



A patient is placed on a ventilator at the beginning of LTCH stay, or is placed on a ventilator during the stay, but is subsequently weaned from the ventilator during the stay.

Ventilator code **must be submitted** on the claims, including discharge claim.

A patient had a laparoscopic lysis of peritoneal adhesions, ICD-9-CM procedure code 54.51.

ICD-9-CM procedure code 54.51 **must be reported** on all claims submitted for the duration of the patient's stay at the LTCH.

Role of the Quality Improvement Organization



LTCHs must have an agreement with a Quality Improvement Organization (QIO), formerly known as the Peer Review Organization (PRO), to have the QIO review the following on an ongoing basis:

The medical necessity, reasonableness, and appropriateness of hospital admission and discharges

Inpatient hospital care for which outlier payments are sought

Validity of the hospital's diagnostic and procedural information

Completeness, adequacy and quality of the services furnished in the hospital

Other medical or other practices with respect to beneficiaries or billing for services furnished to the beneficiaries.

Physician Acknowledgement Statement



Physicians must complete an acknowledgement statement to indicate they understand that Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. The LTCH must maintain this signed acknowledgement for each attending physician.

Content of Physician Acknowledgement Statement

When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice.

Notice to Physicians

“Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

Completion of Acknowledgement

The acknowledgement must be completed by each physician at the time the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient.

Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

Denials Based on Admissions and Quality Review

If CMS determines on the basis of information supplied by a QIO that a hospital has misrepresented admissions, discharges or billing information, or has taken an action that results in unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries, CMS may as appropriate:

Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

Medical Review by the FI



As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicate LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule. In such cases, the days of a stay failing medical review will be excluded from the qualification computation for the LTCH's cost reporting period.

The current Appeal, Right to Hearing and Office of Inspector General guidelines also remain the same.

Furnishing of Inpatient Hospital Services Directly or Under Arrangement

LTCHs must furnish all necessary covered services to Medicare beneficiaries who are inpatients of the hospital either directly or under arrangements.

Medicare will not pay any provider or supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH, except those services not included as inpatient hospital services.

All covered services must be provided by the appropriate clinician. Clinicians providing services to a beneficiary in an LTCH must be licensed and/or credentialed in the state where the service is performed and working within the scope of their license.

A Clinician Is:

An employee of the LTCH or an employee contracted by the LTCH.

Claims for the Part B Carrier

Claims are also submitted to the Part B Carrier based on the clinician providing the service.

Claims for the clinicians listed below should be submitted to the Part B Carrier servicing the facility.

Physician's services

Certified nurse midwife services

Physician assistant services

Qualified psychologist services

Nurse practitioners services

Anesthetist services

Clinical nurse specialist services

Documentation

Generally, LTCHs are distinguished from other inpatient hospital settings by an average length of stay greater than 25 days.

Two special payment situations related to length of stay impact clinicians and/or medical records.

1. **Short-stay outliers** have stays of considerably less than the average length of stay. The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment.
2. **Interrupted stays** are cases in which an LTCH patient is discharged from the LTCH and admitted to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed and ultimately returns to the same LTCH within a fixed period of time. The fixed period of time is defined by the type of facility receiving the beneficiary after discharge from the LTCH. The interrupted stay case is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made.

Short-Stay Outliers

LTCH stays that are between one day and up to and including 5/6 of the geometric average length of stay of the LTC-DRG are considered to be **short-stays**.

Short-stay outliers may be caused by any of the following clinically-based situations:

It is determined after admission to the LTCH that the beneficiary would receive more appropriate care in another setting; Typically the patient experiences an acute episode or requires more intensive rehabilitation therapy than is available at the LTCH. The patient is then discharged and not subsequently readmitted because they no longer require LTCH-level treatment.

The patient may be discharged to their home.

The patient expires within the first several days of being admitted to an LTCH.

The patient may not require the type of care generally provided in an LTCH.

The patient may require urgent treatment at another site of care.

Obviously, with a short-stay, the beneficiary frequently receives less than the full course of treatment at the LTCH before being discharged.

Medical record documentation should be clear, concise and the support services provided to the beneficiary during their LTCH admission.



Interrupted Stay

Interrupted stays are cases in which an LTCH patient is discharged to another type of facility for services that may not be available at the LTCH and returns to the LTCH for further treatment within a fixed period of time. The fixed periods range from 9 to 45 days depending on the type of facility receiving the discharged LTCH patient.

The fixed periods vary by facility type as follows:

- Inpatient acute care hospital within 9 days
- Inpatient Rehabilitation Facility (IRF) within 27 days
- Swing-bed hospital within 45 days
- Skilled Nursing Facility (SNF) within 45 days



Part of the reasoning behind this policy is that CMS wanted to ensure that any discharge from an LTCH to another Medicare provider that was then followed by a re-admittance to the LTCH was based on clinical considerations, i.e., that the patient received a full course of treatment at the other facility, rather than on financial incentives for another discharge payment.

Cases that meet the interrupted stay criteria are considered a single discharge from the LTCH and therefore only one LTC-DRG payment is made to the LTCH.



This potentially creates an interesting administrative issue for LTCH providers since they must take appropriate steps to ensure that coding and medical record documentation for both admissions are included in the interrupted stay LTC-DRG and that they are available for review. Again, it is also very important that the principal diagnosis reflect the admission principal diagnosis on all claims submitted.

If a request for medical record documentation occurs, the provider should **forward the medical documentation for both admissions included in the interrupted stay claim** to the QIO or FI, as applicable, to support the assigned LTC-DRG.

If an LTCH patient's discharge to an acute care hospital, IRF, Swing-bed or SNF is longer than the specified length of discharge stay for that provider, the subsequent readmission to the LTCH would be considered a new admission, not an interrupted stay. Therefore, the records from the two separate admissions can be maintained separately and the ICD-9-CM coding must be reported independently on two separate claims.

LTCH PPS Billing

LTCH PPS billing considerations

Objective

This chapter addresses the many important billing aspects of the new Long-Term Care Hospital prospective payment system.

Participants will learn about the following information in the course of this chapter:

The LTCH PPS billing implementation effective date.

Medicare billing requirements not affected by LTCH PPS.

New Medicare billing requirements for LTCH PPS.

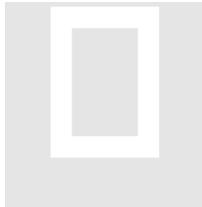
Medicare billing requirements for claims within the transition period to LTCH PPS.

Medicare billing requirements for PPS providers with which LTCHs may not be familiar.

LTCH PPS Implementation Schedule

LTCH PPS is effective on the first day of the LTCH's cost reporting period that begins on or after October 1, 2002. LTCHs will transition to the LTCH PPS on the first day of their cost reporting period that begins on or after October 1, 2002. See Table 4.1 for examples of LTCH PPS effective dates.

Table 4.1 Examples of LTCH PPS Effective Dates



Cost Report Period Start Date	LTCH PPS Effective Date
October 1, 2002	October 1, 2002
January 1, 2003	January 1, 2003
April 1, 2003	April 1, 2003
July 1, 2003	July 1, 2003



Guidelines for billing Medicare under LTCH PPS are applicable to Medicare Part A fee-for-service long-term care services and effective for discharges beginning on or after the LTCH's cost reporting period that begins on or after October 1, 2002.

Under the fully implemented LTCH PPS, Medicare will pay each LTCH discharge from an LTCH based upon the LTC-DRG to which it is assigned.

LTCH provider's claims will be payable under the policies of the LTCH Prospective Payment System on the first day of that provider's cost reporting period that begins on or after October 1, 2002.

Standard Systems Delay



Unfortunately, the standard processing systems will not have the necessary computer system changes in place to fully accommodate claims processing and payment under the LTCH Prospective Payment System until after January 1, 2003. Therefore, although claims by LTCHs will be payable under the LTCH PPS following October 1, 2002, actual payments during the interim will be made using the pre-existing procedures.

However, beginning October 16, 2002, all LTCHs will be required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act. This requirement means LTCHs must submit claims in compliance with the standards at 42 CFR 162.1002 and

LTCH PPS BILLING

45 CFR 162.1192 and use the ICD-9-CM coding. All ICD-9-CM coding must be used by LTCH providers with cost reporting period beginning on or after October 1, 2002.

After the standard systems are updated, the Medicare payments made to LTCHs from cost reporting periods that began on or after October 1, 2002 will be reconciled based on the LTCH prospective payment methodology.



LTCHs are not required to hold the submission of claims to Medicare until the standard processing systems are ready. It is essential that, when submitting claims, LTCHs utilize LTCH PPS billing guidelines and correct coding techniques for any discharges payable under the LTCH PPS. In other words, each LTCH should use the new guidelines and coding as soon as the LTCH PPS is effective for that provider, regardless of whether the standard systems are ready.

Billing Requirements Unchanged by the Implementation of LTCH PPS

Once an LTCH has transitioned to the LTCH PPS, it should bill Medicare in accordance with the new LTCH PPS billing instructions and with the existing applicable Medicare billing instructions for Acute Care Hospital PPS (also known as Inpatient PPS) providers.

However, many of the requirements for hospitals excluded from inpatient PPS, under which LTCHs were billing, are the same as the acute care hospital PPS billing requirements and will therefore not be changed as a result of the implementation of the LTCH PPS.

FI and CWF Processing

Claims must be submitted to the FI for processing and will be subject to various claims processing edits. Once processed by the FI, claims will be sent to the Common Working File (CWF) for additional editing and posting in the beneficiary's national Medicare record.

Timely Filing

Claims must be submitted to the FI in a timely manner. For dates of service January 1 to September 30, the timely filing limit is December 31 of the following year. For dates of service October 1 to December 31, the timely filing limit is December 31 of the second year following the date of service.



Examples:

If the date of service is between January 1, 2002 and September 30, 2002, the claim must be submitted to the FI by December 31, 2003

If the date of service is between October 1, 2002 and December 31, 2002, the claim must be submitted to the FI by December 31, 2004

Bill Types and Claim Change Reason Codes

LTCH inpatient claims should be submitted on a “11X” type of bill. Please note that types of bill 113, 114, and 115 will no longer be appropriate for LTCHs to use. A 117 type of bill is used for adjustments, while a 118 type of bill is used for cancels. Claim adjustments and cancels can be submitted using established guidelines.

The “Claim Change Reason Codes” are listed on the next page. Providers should submit one code with each adjustment or cancel request. If multiple requests are necessary, the provider should choose the single reason that best describes the request. The code “D1” should be used only when the charges are the only change on the claim. Other claim change reasons frequently also change charges, but providers should not "add" reason code “D1” when this occurs.

Table 4.2 Claim Change Reason Codes

Bill Type	Reason Code	Explanation
xx7	D0 (zero)	Change to service dates
xx7	D1	Change in charges
xx7	D2	Change in revenue codes/HCPCS
xx7	D3	Second or subsequent interim PPS bill
xx7	D4	Change in GROUPER input (diagnoses or procedures)
xx8	D5	Cancel-only to correct a HICN or provider identification number
xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.
xx7	D7	Change to make Medicare the secondary payer
xx7	D8	Change to make Medicare the primary payer
xx7	D9	Any other change
xx7	E0 (zero)	Change in patient status

General Coding

LTCHs will submit claims according to Section 3604 of the Medicare Intermediary Manual. Claims are to be prepared using established guidelines for general coding. This includes, but is not limited to the guidelines for ancillary services, leaves of absence and Medicare Secondary Payer (MSP) billing.

Patient Status Codes

Although the implementation of LTCH PPS does not include the development of new patient status codes, you may find it helpful to review the three patient status (discharge status) codes have been added to the existing inpatient patient status codes in the last two years.

Program Memorandum A-01-86, published July 24, 2001, introduced two new patient status codes to indicate when a patient is discharged to another inpatient rehabilitation facility (patient status 62) or a long-term care hospital (patient status 63). These new patient status codes were effective as of January 1, 2002.

Program Memorandum A-02-022 published March 22, 2002 clarified Program Memorandum A-01-86. The word “another” was removed from the definition of patient status code 62. The definition currently indicates that a patient is discharged/transferred to an inpatient rehabilitation facility (IRF).

Program Memorandum A-02-041 published May 17, 2002 introduced a new patient status code to indicate when a patient is discharged/transferred to a Skilled Nursing Facility (SNF) certified under Medicaid but not certified under Medicare (patient status 64). This new patient status code will be effective for discharges on or after October 1, 2002.



It is important that providers indicate the appropriate patient status code when billing Medicare. However, under LTCH PPS, there are no special payment policies for transfer cases, other than for interrupted stays.

Patient Status Codes and Definitions

Table 4.3 Patient Status Codes

PSC	Definition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to SNF (For hospitals with an approved swing-bed arrangement, use Code 61-Swing-bed)
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharge/transferred to home under care of a home IV drug therapy provider
20	Expired (or did not recover - Christian Science Patient)
30	Still a patient
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing-bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF)
63	Discharged/transferred to a long-term care hospital (LTCH)
64	Discharged to a Skilled Nursing Facility (SNF) certified under Medicaid but not certified under Medicare

Ancillary Services

Payment may be made under Part B for certain services when furnished by a participating LTCH to an inpatient of that hospital when payment for these services cannot be made under Medicare Part A. The billing rules for ancillary services continue to apply under LTCH PPS.

When coding LTCH PPS bills for ancillary services associated with a Part A inpatient stay, the bill type is 12X and the traditional revenue codes will continue to be shown in conjunction with the appropriate entries in the Service Units, and Total Charges fields. LTCH providers should also:

Report the number of units based on the procedure or service

Report the actual charge for each line item in Total Charges

Report the date of service for each line item (“line item date of service”) with appropriate HCPCS coding

Reference:

For a complete list of medical items and other services that can be billed under this provision or for more information concerning covered ancillaries, providers may refer to the CMS Hospital Manual, Pub.10 Sections 228 and 431 or Pub.13 Section 3626.1.

Pre-Admission Services

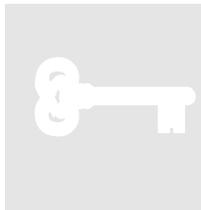
The Medicare billing rule for pre-admission services remains the same for LTCHs under LTCH PPS as it was under the prior payment method. LTCHs remain subject to the Medicare billing rule for pre-admission services that fall within 24 hours prior to the beneficiary’s admission. Although LTCHs will now be paid under a prospective payment method, they should not utilize the 72-hour rule for pre-admission services that inpatient acute care PPS providers do. LTCHs may refer to the CMS Hospital Manual, Pub.10, Section 415.6 or Pub. 13, Section 3610.3 for additional information on this subject.

Adapting Existing IPPS Requirements for LTCH PPS Billing

Prior to the implementation of the LTCH PPS, LTCHs billed using the requirements for hospitals excluded from the inpatient PPS. As previously mentioned, once an LTCH has transitioned to the LTCH PPS, it should bill Medicare in accordance with the new LTCH-specific billing instructions and existing applicable Medicare billing instructions for Acute Care Hospital PPS providers. This will result in a change in Medicare billing requirements for LTCHs.

One new major factor for LTCHs to consider, especially when applying the billing guidelines from the Acute Care Hospital PPS to claims billed under LTCH PPS is the impact benefit utilization has on payment.

Under the Acute Care Hospital PPS, the basic prospective payment amount is paid to the provider if the beneficiary has at least one benefit day remaining at the time of admission.



However, under the LTCH PPS, Medicare will pay an LTCH a full LTC-DRG if a patient has sufficient Medicare benefit days to exceed the number of days that would categorize the case as a short-stay outlier (i.e., greater than 5/6 of the ALOS for the particular LTC-DRG assigned).

A short stay outlier payment is generated when the patient has benefit days to exceed the short stay outlier threshold, but the stay itself does not exceed the short stay outlier criteria.

If a patient does not have sufficient Medicare benefit days to exceed the number of days that would categorize the case as a short-stay outlier (i.e., equal to or less than 5/6 of the ALOS for the particular LTC-DRG assigned), then a short-stay outlier payment is generated.

This is different than the TEFRA reasonable cost payment system that LTCHs previously used. It is also different than the Acute Care Hospital PPS. This difference impacts the way, in which some claims must be coded, particularly claims impacted by an exhaustion of benefits and high cost outliers, which will be reviewed later.

The examples on the next few pages should help illustrate the availability of benefits and its relationship to the payment of the claim.

Lifetime Reserve (LTR) Days – Policy for Use

Before looking at each example, the policy regarding the use of lifetime reserve (LTR) days in the LTCH PPS must be clear.

If a beneficiary did not have enough regular Medicare days to exceed the short stay outlier threshold, the beneficiary could use his/her LTR days to exceed the short stay outlier threshold so that a full LTC-DRG payment could be generated. However, under LTCH PPS, once a beneficiary starts using LTR days, they must continue to use them for each remaining day of hospitalization for that episode of care, even if no additional Medicare payments are generated, until any applicable high cost outlier threshold is reached.

The beneficiary continues to maintain the right to elect not to use the LTR days to either exceed the short stay outlier threshold or within the high cost outlier period. However, the choice not to use the LTR days would result in beneficiary liability. If the beneficiary elects to use LTR days, the days must continue to be used until the patient is discharged.

Benefit Availability and Full LTC-DRG Payment

Remember that under LTCH PPS, Medicare will pay a full LTC-DRG payment when the length of stay **exceeds** the short stay outlier criteria (5/6 of the ALOS for the assigned LTC-DRG) **and** the patient has benefits available for each day up to this point.

It is also important to note that as soon as the patient's stay exceeds the short stay outlier criteria, the full LTC-DRG is applicable.

Please Note:

In each of the following examples, it is assumed that the patient **does** elect to use any available LTR days and that each case is **not** a high cost outlier situation.

Example—Full LTC-DRG Paid

Patient is admitted to the LTCH on 11/01/02 and discharged on 11/30/02 for a total stay of 29 days.

The average length of stay (ALOS) for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.

At admission, the patient has 15 coinsurance days and 3 LTR days.



The case is payable at full LTC-DRG because the length of stay exceeds the short stay outlier threshold (29 days > 10 days) and the patient has enough benefits to exceed the short stay outlier criteria (18 days > 10 days).

Benefit Availability and Short Stay Outlier Payment

Remember that under LTCH PPS, Medicare will pay a short-stay outlier payment when the length of stay is equal to or less the short stay outlier threshold. This may occur if the patient is discharged or dies before the length of stay exceeds the short stay outlier criteria. The short stay outlier payment is made with respect to the number of days for which the beneficiary had benefits available. The first short stay outlier example reflects this situation:

Short Stay Outlier Payment: Example #1

Patient admitted to LTCH on 10/10/02 and discharged on 10/19/02 for a total stay of 9 days.

The ALOS for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.

At admission, the patient has 20 coinsurance and 0 LTR days available.

The case is **payable as a short stay outlier** (even though the patient has enough benefit days to cover the entire stay) **because the entire stay does not exceed the ALOS** for the LTC-DRG (9 days < 10 days). The short stay outlier payment will be made with respect to 9 days.

Remember that Medicare will pay a short stay outlier when the length of stay exceeds the short stay outlier threshold for the assigned LTC, but the patient has only enough benefits available to cover up to and including the short stay outlier threshold for the assigned LTC-DRG. This may occur if the patient exhausts Medicare benefits before the length of stay exceeds the short stay outlier criteria. The short stay outlier payment is made with respect to the number of days for which the beneficiary had benefits available. The second short stay outlier example reflects this situation:

Short Stay Outlier Payment: Example #2

Patient is admitted to the LTCH on 10/10/02 and discharged on 10/30/02 for a total stay of 20 days.

The ALOS for the assigned LTC-DRG is 12 days and 5/6 of this is 10 days.



At admission, the patient has 3 coinsurance days and 7 LTR days.

The case is payable as a short stay outlier because the patient does not have enough benefits available to the short stay outlier threshold for the assigned LTC-DRG (10 days = 10 days). The short stay outlier payment will be made with respect to 10 days.

It is important to remember that under the short stay outlier policy providers are paid the least of the three calculations described in the Payment Section of this Training Guide. **That is, Medicare will pay the lesser of 120% of a per diem payment calculated for that LTC-DRG, 120% of the cost of the case, or the full LTC-DRG.**



The policy underlying this formula is that the payment increases as the length of stay approaches the average length of stay for the LTC-DRG. When the payment made under the short stay outlier policy (the lowest of the three payment options) is 120% of the LTC-DRG per diem and the patient's length of stay is exactly equal to 5/6 of the average length of stay of the LTC-DRG, the short stay outlier payment will actually be the full LTC-DRG payment, which would be the lowest of the three payment options.

Therefore, in this example, we would compute the payment under the short stay policy because the day count did not exceed the average length of stay for the LTC-DRG, but in effect, for this case, Medicare would pay the full LTC-DRG.

This example proves that the mathematical logic underlying the short stay outlier policy has considerable legitimacy.

If the situation were the same but, at admission, the patient has three coinsurance and one LTR day, the case would be payable as a short stay outlier because the patient does not have enough benefits available to exceed the short stay outlier threshold for the assigned LTC-DRG (4 days < 10 days) and the short stay outlier payment will be made with respect to four days.

At admission, these patients would have to have at least 11 benefit days available for the case to exceed the short stay outlier threshold and be payable at a full LTC-DRG (11 days > 10 days).

LTCH PPS BILLING

Table 4.4 outlines the above examples plus several additional scenarios.



<i>ALOS of LTC-DRG</i>	<i>Short Stay Outlier Threshold (5/6 of ALOS)</i>	<i>Actual Length of Stay</i>	<i>Payable as Short Stay Outlier</i>	<i>Benefit Days Available (Full/Co/LTR)</i>	<i>LTR Used Assuming patient elects to use if needed.</i>	<i>Medicare-Payable Days</i>
12	10	29	No	0/15/3	0	29
12	10	9	Yes	0/20/0	0	9
12	10	20	Yes	0/3/7	7	10
12	10	20	Yes	0/3/1	1	4
12	10	20	No	0/9/2	2	20
30	25	25	Yes	0/15/30	10	25
30	25	20	Yes	0/15/30	5	20
30	25	27	No	0/15/30	12	27
30	25	29	No	0/25/30	4	29
30 Beneficiary "A"-Chapter 2	25	35	No	0/26/30	0	35
30	25	45	No	0/26/30	0	45
30 Beneficiary "B"-Chapter 2	25	35	No	0/10/30	25	35

New Billing Requirements Under LTCH PPS

The following subjects relate to billing requirements and concepts that, under LTCH PPS, are new to the LTCH. These subjects include new billing instructions from the LTCH PPS Final Rule as well as the requirements from the CMS Manual, Pub.10 for PPS providers subject to a PPS.

One Claim Per Stay

After the implementation of the LTCH PPS, only one claim will represent an entire inpatient stay. The following topics provide an explanation of this new billing concept for LTCHs.



Interim Billing

Providers under periodic interim payments (PIP) are **not** allowed to submit interim bills under LTCH PPS.

Providers that are **not** under PIP and are experiencing unusually long stays **are** permitted to submit interim bills.

These non-PIP providers may bill for the 60 days after an admission and every 60 days thereafter.

The first 60-day interim bill should be submitted to Medicare using a 112 type of bill. The non-PIP LTCH may submit subsequent changes to the 112 type of bill by using type of bill 117 (adjustment) with claim change reason code D3.

Sequential billing, using types of bills 113 and 114, is not allowed under the LTCH PPS.

Late Charge Billing

Late charge claims (type of bill 115) are **not** permitted under LTCH PPS. If a provider has late charges to add to a claim that has been processed by Medicare, an adjustment bill (type of bill 117) must be submitted.



Split Billing

Payment under LTCH PPS is based on discharge. As a result, split billing is no longer required when claims cross a provider's PPS effective date, fiscal year, or the CMS fiscal year (October 1st).

Claims Crossing the LTCH PPS Transition Date

The elimination of split billing also means that claims for services that cross over the date of transition to the new prospective payment system are allowed because payment under LTCH PPS is based on the discharge date.

Note:

It is important that claims crossing the LTCH's implementation date for LTCH PPS be coded using the new LTCH PPS requirements.



Patients Who Are Currently Inpatients When Transition to PPS Occurs

Although claims for services that cross over the date of transition are allowed, it is possible that an LTCH may have submitted interim claim(s) for beneficiaries who were admitted before the transition to LTCH PPS, but discharged after it.

Therefore, before submitting a new claim to Medicare for such patients, **the LTCH should first review its Medicare claim submission history.**

If no interim bills have been submitted prior to the implementation of LTCH PPS, the provider should submit one bill, from admission through discharge for discharges occurring after the implementation of LTCH PPS. No special coding, other than LTCH PPS coding, is required on a claim that crosses over the facility's transition date.

If an interim bill or multiple interim bills have been submitted prior to the implementation of LTCH PPS, but the beneficiary is discharged after the implementation of PPS, the LTCH should follow the guidelines below:

**One Interim Claim
Previously
Submitted**

If only one interim claim had previously been submitted to Medicare and processed for a patient who is being discharged after the implementation of LTCH PPS, the claim must bill adjusted using a 117 type of bill (adjustment) to add services through discharge using the appropriate LTCH PPS coding.

**Multiple Interim
Claims Previously
Submitted**

If multiple interim claims had previously been submitted to Medicare and processed for a patient who is being discharged after the implementation of LTCH PPS, all such interim claims must be cancelled using a 118 type of bill (cancel). After all of the cancellations of the interim claims have been finalized, one new claim must be submitted from admission through discharge using the appropriate LTCH PPS coding. Or, all of the 113 types of bills must first be cancelled. After all of the cancellations have been finalized, an adjustment to the 112 type of bill can be submitted to add services through discharge using the appropriate LTCH PPS coding.



**Disclaimer for Providers Who Transition to PPS Between
October 1, 2002 and January 1, 2003**

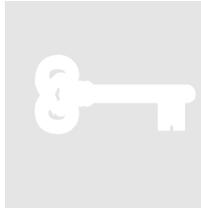
For LTCH providers with PPS transition dates prior to the implementation of the systems changes scheduled on or about January 1, 2003, the above sections on “Split Billing,” “Claims Crossing at the LTCH PPS Transition Dates,” and “Patients Who Are Currently Inpatients When Transition to PPS Occur” have the following applicable changes:

Currently, there are edits in place that prohibit the submission of claims that span an LTCH’s fiscal year start date. These edits require the hospital to split the bill over the cost report begin date. Until LTCH PPS systems changes are in place, LTCHs must continue to split their bills if there are patients in the LTCH when the LTCH transitions over to PPS in order to receive payment. Once the changes are implemented, pre-PPS bills must be cancelled and the entire stay should be re-billed using the PPS guidelines explained in the aforementioned sections

Interrupted Stays

Another situation within the “one claim for the entire stay” concept is the interrupted stay.

Interrupted stays are those cases in which a Medicare beneficiary is discharged from the LTCH and admitted to an acute care hospital, an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF) including Swing-beds and returns to the same LTCH within a fixed day period.



Under LTCH PPS, **one claim should be submitted** when there has been an interrupted stay. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made.

Fixed-Day Periods

The fixed-day period during which the Medicare beneficiary must return to the LTCH differs for each facility type within the interrupted stay policy. Each fixed day period of time is dependent upon the facility type to which the patient is being admitted to upon discharge from the LTCH.

For a discharge to an acute care hospital, the applicable fixed day period is 9 days or less.

For a discharge to an IRF, the applicable fixed day period is 27 days or less.

For a discharge to a SNF or Swing-bed, the applicable fixed day period is 45 days or less.

The counting of the days begins on the day of discharge from the LTCH and ends on either the 9th day, 27th day or 45th day after the discharge depending on the facility type.



Interrupted Stay: Example #1-A

If a patient is admitted to an LTCH on 10/05/02 and is discharged from the LTCH and admitted to an acute care hospital on 10/10/02, the day count of the interruption begins on 10/10/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the ninth day after discharge, which is on or before 10/18/02.



Interrupted Stay: Example #2-A

A patient is admitted to an LTCH on 10/05/02. The patient is discharged from the LTCH and admitted to an IRF on 11/30/02. The day count of the interruption begins on 11/30/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 27th day after discharge, which is on or before 12/26/02.



Interrupted Stay: Example #3-A

If a patient is admitted to an LTCH on 10/05/02 and is then discharged from the LTCH and admitted to a SNF or Swing-bed on 10/10/02, the day count of the interruption begins on 10/10/02. To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 45th day after discharge, which is on or before 11/23/02.



If the length of stay at the receiving site of care falls within the above-listed fixed periods of time, then the original stay and the second LTCH stay would be billed to Medicare on **one** claim. This claim must also reflect the period of time (interrupted stay) that the patient spent at the receiving site of care.

Multiple Interrupted Stays

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

Situations That Are Not Interrupted Stays

There are three “discharge then readmission” situations that do not meet the definition of an interrupted stay under LTCH PPS:

1. If the length of stay at the “receiving” site of care exceeds the above-listed fixed periods of time, then the return to the LTCH will be a new admission.
2. If the “receiving” site of care is not an acute care hospital, an IRF, Swing-bed or a SNF, the return to the LTCH will be a new admission.
3. If the patient is admitted to more than one facility before returning to the LTCH, or goes home between LTCH stays, the return to the LTCH will be a new admission.

In all of these situations, this means that the original stay at the LTCH will be treated as a discharge for payment purposes and the new admission through discharge will also be treated as a discharge for payment purposes; therefore, two separate payments will be made to the LTCH.

LTCH Length of Stay Determines Payment Policy

The total number of covered days of a patient's length of stay in an LTCH prior to and following the interrupted stay determine the LTCH PPS payment policy that applies to the claim. The first date of discharge is counted as an interruption day. The date of the return to the LTCH is a benefit day and counts toward utilization. The second date of discharge, consistent with existing regulations, is not payable and does not count toward utilization.

Payment is determined at final discharge. Medicare would pay for the episode of care at the LTCH as a short-stay outlier or a full LTC-DRG payment based on the length of stay. **Such a stay could also result in high cost outlier payments.**

Likewise, the number of days that the beneficiary is a patient at the other facility during an LTCH interrupted stay, would not be included in determining the length of stay at the LTCH. The receiving site of the interrupted stay is payable under its respective payment method for the time the patient spends in that facility.

Submitting Interrupted Stay Claims to Medicare

An LTCH **may, but is not required to**, hold the submission of a claim to Medicare. **Or**, if an LTCH discharges a patient and then the patient is admitted to one of these facility types, the LTCH may submit the claim to Medicare for services from the initial admission through the second date of discharge.



If a patient returns to the LTCH within the fixed period of time from the acute care hospital, the IRF or the SNF (including swing-beds), the provider would need to review the Medicare claim submission history for each patient for the following.

1. If the LTCH had not already submitted a claim for the original stay to Medicare, then the provider would bill the entire stay on one claim, including the original stay and the second LTCH stay.
2. If the LTCH had already submitted a claim for the original stay to Medicare, the original claim would need to be adjusted using claim change reason code D0 to add the second LTCH stay.
3. If an LTCH mistakenly submitted two separate claims that should have been billed as one claim, the claim for the second stay will need to be cancelled using claim change reason code D6. The claim for the original stay will need to be adjusted using claim change reason code D0 to add the second LTCH.



In each of these cases, the final admission through discharge claim must also reflect the period of time at the “receiving” provider, but not the respective services and charges of that provider. We will discuss the ways in which these days/dates are reflected on the claim next.

Once the standard systems are updated to accommodate LTCH PPS claims processing and payment, Common Working File (CWF) will edit claims that should have been billed as interrupted stays but were not. It will also edit claims that are billed as interrupted stays, but should not have been.

Occurrence Span Code 74 and Accommodation Revenue Code 018X

On the UB-92 claim, the interrupted days are represented with an occurrence span code 74 and an accommodation revenue code of 018X. Providers should continue to use the occurrence span code 74 and the accommodation revenue code 018X in the current manner.

Note: The definitions and use of the 74 occurrence span code and the 018X revenue code are different from the definition of the interrupted stay.

The occurrence span code 74 would reflect the “span code from date” equal to the date of discharge from the LTCH and the “span code through date” equal to the last day the patient was not present at midnight.

The 018X revenue code would reflect the number of days represented within the 74 occurrence span code.



Example #1-B:

In Example #1-A above, the occurrence span code 74 would show a from date of 10/10/02 and a through date of 10/17/02. The 018X revenue code would reflect 8 units.



Example #2-B:

In Example #2A above, the occurrence span code 74 would show a from date of 11/30/02 and a through date of 12/25/02. The 018X revenue code would reflect 26 units.



Example #3-B:

In Example #3A above, the occurrence span code 74 would show a from date of 10/10/02 and a through date of 11/22/02. The 018X revenue code would reflect 44 units.

Interrupted Stay of One Day

There may be situations where a patient is discharged from an LTCH and then admitted to an acute care hospital, IRF or SNF (including swing-beds), but the patient returns to the LTCH by midnight of the same day.



One-day Interruption Example

A patient is admitted to the LTCH on 11/2/02. The patient discharged from the LTCH and admitted to an acute care hospital on 11/10/02 and then returns to the LTCH by midnight on 11/10/02.

This situation meets the criteria of a one-day interrupted stay (because the day count for the interrupted stay policy starts on the date of discharge). **However, no occurrence span code 74 and no revenue code 018X are required on the UB-92.** Interrupted stays of more than one day **do** require this coding on the UB-92.

UB-92 Coding Instructions for Interrupted Stays

To bill a claim to Medicare with an interrupted stay, on the UB-92 indicate:

- The “from” date is the original date of admission
- The “through” date is the final date of discharge
- Payable days go in the covered days field
- Interruption days go in the noncovered days field
- Total days of service on the claim = payable days & interruption days & leave of absence days & noncovered level of care days & days after benefits exhaust if those days fall before the claim exceeds the short stay outlier policy or if those days fall within the high cost outlier period
- Appropriate patient status code (PSC) to show the transfer upon discharge to the acute care hospital (PSC=02), IRF (PSC=62) or SNF (PSC=03) or Swing-bed (PSC=61)
- Occurrence span code 74, for interruptions of more than one day, with the dates the patient spent at the “receiving” provider
- “From date” is date of initial discharge from the LTCH
- “Through date” is the last date the patient is not present at midnight
- Revenue code 018X to show the number of interruption days

LTCH PPS BILLING

- Units equal the number of days reflected in Occurrence span code 74
- No code or charges in HCPCS/Rates field
- Do not list charges in covered or noncovered
- Accommodation revenue code 010X-021X
- Show daily room rate in HCPCS/Rates field
- Show total number of payable and noncovered days (do not list interruption days or LOA days as “noncovered” on this line)
- Charges must equal daily room rate multiplied by number of payable days
- Appropriate coding as required, including ancillary revenue codes and charges on the remainder of the claim

Interrupted Stay Claim Examples

The claim examples that follow show the applicable UB-92 codes to reflect interruptions for each provider type included in the interruption policy (acute care hospital, IRF, and SNF or swing-bed). The examples will show that the patients, in these cases, returned to the same LTCH by the last possible day in the interrupted stay policy. However, the LTCH would code Medicare claims for interruptions for up to and including 9 days for acute care hospitals, up to and including 27 days for IRFs and up to and including 45 days for SNFs (including swing-beds).



Claim Example #1-C – Discharge to and readmission from an acute care hospital

Patient was admitted to an LTCH, discharged from the LTCH, and admitted to an acute care hospital. The patient then returns to the LTCH within the 9-day interruption policy. The example will show the patient returned on the 9th day after discharge.

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.							4 TYPE OF BILL 111									
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 10/05/02 THROUGH: 12/11/02		7 COVD.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11											
12 PATIENT NAME <i>Annie Acute</i>				13 PATIENT ADDRESS															
14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31		
32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE CODE	DATE	37 OCCURRENCE SPAN FROM	THROUGH	38	39	40	41	42	43	44	
39	VALUE CODE CODE	AMOUNT	40	VALUE CODES CODE	AMOUNT	41	VALUE CODES CODE	AMOUNT	42	43	44	45	46	47	48	49	50	51	
42 REV.CD.	43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59	60	
012X	018X	100.00		59	5900	00													
	PLUS ANCILLARY REVENUE CODES AND CHARGES																		
	001 Total Charges				XXXX	XX													
50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58	59	60	61	62	63	64	65	66	67	68	
58 INSURED'S NAME	59 P.REL.	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE
									12345										
79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE						
											Claim Example of a 9-day Interrupted stay at Acute Care Hospital X								

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

Claim Example #2-C – Discharge to and readmission from an IRF

Patient was admitted to an LTCH, discharged from the LTCH and then admitted to an IRF. The patient returns to the LTCH within the 27-day interruption policy. The example will show that the patient returned on the 27th day after discharge.

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.				4 TYPE OF BILL 111															
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 10/05/02 THROUGH 12/31/02		7 COV.D. 61	8 N.C.D. 26	9 C.I.D. 1	10 L.R.D.	11														
12 PATIENT NAME Ronnie Rehab				13 PATIENT ADDRESS																		
14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR 19 TYPE 20 SRC		21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 25 26 27 28 29 30 31 CONDITION CODES													
32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE CODE DATE		37 OCCURRENCE SPAN FROM 11/30/02 THROUGH 12/25/02												
38		39 VALUE CODE CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT																
42 REV.CD.	43 DESCRIPTION			44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES		49												
012X 018X	PLUS ANCILLARY REVENUE CODES AND CHARGES			100.00		61 26	6100 00															
001 Total Charges							XXXX XX															
50 PAYER				51 PROVIDER NO.		52 BEL. 53 ADD. INFO BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56										
57				DUE FROM PATIENT <input type="checkbox"/>																		
58 INSURED'S NAME				59 P.REL		60 CERT.-SSN-HIC.-ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.												
63 TREATMENT AUTHORIZATION CODES		64 ESC		65 EMPLOYER NAME				66 EMPLOYER LOCATION														
67 PRIN. DIAG. CD.		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG.		77 E-CODE		78
12345																						
79 P.C.		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID														
		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		83 OTHER PHYS. ID														
84 REMARKS								OTHER PHYS. ID														
								85 PROVIDER REPRESENTATIVE X				86 DATE										

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Claim Example #3-C – Discharge to and Readmission from a SNF

Patient was admitted to an LTCH and then discharged. Upon discharge from the LTCH, the patient is admitted to a SNF and returns to the LTCH within the 45-day interruption policy. The example will show that the patient returned on the 45th day after discharge.

Patient Classification

Certain data elements on the claim determine the patient classification system grouping into which the claim will fall. The patient classification system groupings are called LTC-DRGs.

Claims submitted for processing to the FI are subject to series of edits called Medicare Code Editor (MCE), which is designed to identify cases that would require further review before classification into a LTC-DRG. After screening by the MCE, each claim is classified into the appropriate LTC-DRG by the Medicare LTCH GROUPEL. The LTCH GROUPEL is specialized computer software based on the GROUPEL utilized by the acute care hospital inpatient prospective payment system. Following the LTC-DRG assignment, the FI determines the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments.

An LTC-DRG is selected from certain information that LTCHs report on the Medicare claim. The information on the Medicare claim must be as accurate and complete as possible, particularly since the Medicare payment is based on the following factors:

- Principle diagnosis
- Up to eight additional diagnoses
- Up to six procedures performed
- Age of the patient
- Sex of the patient
- Discharge status of the patient

Diagnosis and Procedure Codes

The use of diagnosis and procedure codes is not a new billing requirement. And, the placement of accurate diagnosis and procedure codes in the appropriate field locators within the UB-92 claim form is still required.

However, these two types of codes, along with other factors, ultimately determine the LTC-DRG for the claim. Appropriate payment is dependent upon the accuracy of the diagnosis and procedure codes on the claim.



Changes to Processed LTC-DRGs

LTCHs will have the opportunity to review the LTC-DRG assignments made by the FI. An LTCH will have 60 days after the date of the notice of the initial assignment of a discharge to an LTC-DRG (date of the LTCH's Medicare remittance) to request a review of that assignment. Following this 60-day period, the LTCH would not be able to submit additional information with respect to the LTC-DRG assignment or otherwise revise its claim.

The LTCH will be allowed to submit additional information as part of its request. The FI will review that LTCH's request and any additional information and would decide whether a change in the LTC-DRG assignment is appropriate.

If the FI decides that a different LTC-DRG should be assigned, the FI will refer the claim to the appropriate QIO to review the case.

Furnishing of Inpatient Hospital Services Directly or Under Arrangements

In accordance with existing regulations and for consistency with other established hospital prospective payment systems policies, an LTCH must furnish covered services to Medicare beneficiaries either directly or under arrangements.

The LTCH prospective payment will be payment in full for all covered inpatient hospital services. Medicare will not pay any provider or supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH, except for the following services, which should be billed to the appropriate Medicare Carrier:

Physicians' services

Physician assistance services

Nurse practitioners and clinical nurse specialist services

Certified nurse midwife services

Qualified psychologist services

Services of an anesthetist

Benefits Exhausted During Stay



Under regular inpatient hospital PPS, if benefits exhaust during the stay, the PPS provider will still be paid the full basic prospective payment. That is, if a beneficiary has one benefit day available, the hospital is paid the full basic DRG. When acute care hospitals bill Medicare, they do not reflect medically necessary days after benefits exhaust as noncovered.



Under LTCH PPS, if benefits exhaust during the stay before the claim exceeds the short stay outlier criteria, the LTCH will be paid a short stay outlier payment. When the LTCHs bill Medicare in this case, they should reflect medically necessary days in the covered field and medically unnecessary days in the noncovered field.

The FI will determine the date on which benefits are exhausted and apply the appropriate benefits exhaust code (A3), the date benefits exhausted, as well as determine the appropriate benefit application. **Ultimately, the days after benefits exhaust in this case would be noncovered.**

However, if benefits exhaust during the stay but after the claim exceeds the Short-stay Outlier criteria, the LTCH provider will be paid the full LTC-DRG payment.

Benefits Exhaust After Short Stay Outlier Threshold is Exceeded

Once the claim exceeds the short stay outlier criteria, inpatient prospective payment billing rules apply. In other words, if the beneficiary still had regular benefit days available once the short stay outlier criteria threshold was exceeded, these regular benefit days would continue to be applied toward the remaining days within the stay until they exhaust.

In addition, if the regular benefit days exhaust before any applicable high cost outlier threshold is reached, the days between the day the regular benefits exhaust and the day after the day the high cost outlier threshold is reached are considered to be paid but “non-utilized”. As long as the patient did not need to use any available LTR days to exceed the short stay outlier threshold, he/she may retain those LTR days to use within any applicable high cost outlier period. This policy can extend the date on which the patient’s benefits actually exhaust.

When the LTCHs bill Medicare in this case, as with the case of a short stay outlier, they should reflect medically necessary days in the covered field and medically unnecessary days in the noncovered field. However, upon processing the claim for payment, the FI will determine the date on which benefits are exhausted and apply the appropriate benefits exhaust code (A3), the date benefits exhausted, the span code 70 representing non-utilized days as described above and the appropriate benefit application.

If necessary, the claim will be returned to the provider with an explanation of the appropriate benefit application and coding and request any additional changes to the claim required by the LTCH.

Note:

In both of these cases, the FI also determines the number of cost report days, which are the number of days for which Medicare is actually making

payment, not the number of days utilized by the beneficiary. These days include non-utilization days (days within the 70 span code).

Coding Benefits Exhaust During the Stay

For LTCHs, under LTCH PPS, to bill a claim where benefits exhaust during the stay, they should use the following instructions:

Use type of bill 11X.

Report covered and noncovered days as usual.

Report the accommodation revenue code(s) and ancillary charges with their respective covered and noncovered units and charges

Remainder of claim is coded using existing requirements

The next several pages contain five benefits exhausted claim examples as they would appear after the initial FI processing. The first two are examples of claims that meet the short stay outlier criteria (and payable a short stay outlier) where the patients have exhausted benefits. The next three examples are of claims that exceed the short stay outlier criteria (and paid the regular LTC-DRG) where the patient has exhausted benefits. In these three examples, it is assumed that:

1. The high cost outlier threshold amount is \$50,000 (although none of these examples have a high cost outlier that is payable)
2. The threshold amount is reached on the 25th day
3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days
4. The billed charges are \$3,000 per day for the first 12 days, \$2,000 on the 13th day and \$1,000 each day thereafter
5. Beneficiary elects to use any available LTR days

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.							4 TYPE OF BILL 111							
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 01/01/03 THROUGH: 01/31/03		7 COVD.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11 9 0									
12 PATIENT NAME Patient # 1-b				13 PATIENT ADDRESS Benefits Available at Admit = 9 co and 0 LTR													
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE SPAN CODE FROM THROUGH	37 A B C	38	39 VALUE CODE CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT								
A3	01/09/03																
42 REV.CD.	43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49										
012X		500.00		30	4500 00	10500 00											
	PLUS ANCILLARY REVENUE CODES AND CHARGES				22500 00	17500											
001	Total Charges				27000	28000 00											
50 PAYER		51 PROVIDER NO.		52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	56								
57 DUE FROM PATIENT																	
58 INSURED'S NAME				59 P.REL.		60 CERT.-SSN-HIC.-ID NO.		61 GROUP NAME	62 INSURANCE GROUP NO.								
63 TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION											
67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78						
12345																	
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID										
	OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		83 OTHER PHYS. ID										
84 REMARKS	Short Stay Outlier						OTHER PHYS. ID	85 PROVIDER REPRESENTATIVE	86 DATE								
								X									

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LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.							4 TYPE OF BILL 111								
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 01/01/03 THROUGH: 01/31/03		7 COVD.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11										
12 PATIENT NAME Patient # 4				13 PATIENT ADDRESS Benefits Available at Admit = 9 LTR														
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31	
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE SPAN FROM	39 OCCURRENCE SPAN THROUGH	40	41	42	43	44	45	46	47	48	49	
A3	01/09/03																	
38	39 VALUE CODE	40 VALUE CODES	41 VALUE CODES	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56
	a	b	c	d														
42 REV.CD.	43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49											
012X		500.00		30	4500 00	10500 00												
	PLUS ANCILLARY REVENUE CODES AND CHARGES				22500 00	17500 00												
001	Total Charges				27000 00	28000 00												
50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56												
57	58 INSURED'S NAME	59 P.REL.	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.													
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION															
67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78							
12345																		
79 P.C.	80 PRINCIPAL PROCEDURE	81 OTHER PROCEDURE	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE											
					Short Stay Outlier Cost Report Days = 9	X												

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.							4 TYPE OF BILL 111								
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 01/01/03 THROUGH: 01/31/03		7 COVD.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11										
12 PATIENT NAME Patient # 1-c				13 PATIENT ADDRESS Benefits Available at Admit = 9 co and 10 LTR														
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31	
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE SPAN FROM	37 OCCURRENCE SPAN THROUGH	37 A	37 B	37 C	37 D	37 E	37 F	37 G	37 H	37 I	37 J	37 K	37 L
A3	01/25/03	47	01/26/03		70	01/20/03	01/25/03											
38	39 VALUE CODE	40 VALUE CODES	41 VALUE CODES	42 REV.CD.	43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49							
	a	b	c	012X		500.00		30	12500 00	2500 00								
	d				PLUS ANCILLARY REVENUE CODES AND CHARGES				40000 00	2500 00								
				001	Total Charges				37500 00	5000 00								
50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58 INSURED'S NAME	59 P.REL.	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.						
							DUE FROM PATIENT											
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78			
				12345														
79 P.C.	80 PRINCIPAL PROCEDURE	81 OTHER PROCEDURE	OTHER PROCEDURE	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE										
	CODE DATE	CODE DATE	CODE DATE			Full LTC-DRG Cost Report Days = 25	X											

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.							4 TYPE OF BILL 111							
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 01/01/03 THROUGH: 01/31/03		7 COVD.	8 N.C.D.	9 C.I.D.	10 L.R.D.	11									
12 PATIENT NAME Patient # 2-c		13 PATIENT ADDRESS Benefits Available at Admit = 15 co and 0 LTR															
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE	39 OCCURRENCE DATE	40 OCCURRENCE CODE	41 OCCURRENCE DATE	42 OCCURRENCE CODE	43 OCCURRENCE DATE	44 OCCURRENCE CODE	45 OCCURRENCE DATE	46 OCCURRENCE CODE	47 OCCURRENCE DATE	48 OCCURRENCE CODE	49 OCCURRENCE DATE
A3	01/25/03	47	01/26/03					70	01/16/03	01/25/03							
38	39 VALUE CODE	40 VALUE CODES	41 VALUE CODES	42 VALUE CODES	43 VALUE CODES	44 VALUE CODES	45 VALUE CODES	46 VALUE CODES	47 VALUE CODES	48 VALUE CODES	49 VALUE CODES	50 VALUE CODES	51 VALUE CODES	52 VALUE CODES	53 VALUE CODES	54 VALUE CODES	55 VALUE CODES
42 REV.CD.	43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	50	51	52	53	54	55	56	57	58	59
012X		500.00		30	12500 00	2500 00											
	PLUS ANCILLARY REVENUE CODES AND CHARGES				37500 00	2500 00											
	001 Total Charges				50000 00	5000 00											
50 PAYER	51 PROVIDER NO.	52 REL	53 ASG	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	57	58	59	60	61	62	63	64	65	66	67
57	58 INSURED'S NAME	59 P.REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	63	64	65	66	67	68	69	70	71	72	73	74
63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	67	68	69	70	71	72	73	74	75	76	77	78	79	80
67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78	79	80	81	82	83	84
12345																	
79 P.C.	80 PRINCIPAL PROCEDURE	81 OTHER PROCEDURE	82 OTHER PROCEDURE	83 OTHER PROCEDURE	84 OTHER PROCEDURE	85 OTHER PROCEDURE	86 OTHER PROCEDURE	87 OTHER PROCEDURE	88 OTHER PROCEDURE	89 OTHER PROCEDURE	90 OTHER PROCEDURE	91 OTHER PROCEDURE	92 OTHER PROCEDURE	93 OTHER PROCEDURE	94 OTHER PROCEDURE	95 OTHER PROCEDURE	96 OTHER PROCEDURE
84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101
	Full LTC-DRG																
	Cost Report Days = 25																

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

High Cost Outliers

Under LTCH PPS, additional payments will be made for those cases that are high cost outliers. These are cases that are classifiable into a specific LTC-DRG, but also have an exceptionally high cost relative to the cost of most discharges.

The high cost outlier payment applies only after accumulated covered charges reach the high cost outlier threshold amount. Under the LTCH PPS, the high cost outlier threshold amount is the LTC-DRG payment plus a fixed-loss amount. The fixed-loss amount for fiscal year 2003 is \$29,852.00.



High cost outlier payments apply to days within the “outlier period”.

The outlier period is a period of time that begins on the day after the day the provider’s accumulated charges reach the cost outlier threshold.

If a patient’s benefits exhaust before the cost outlier threshold is reached, a high cost outlier payment will **not** be made. If a patient’s benefits exhaust after the cost outlier threshold is reached, a high cost outlier payment will **apply only to medically necessary days for which the patient has benefits available**.

Upon receipt of a claim, the FI will determine an appropriate additional payment for inpatient services where the provider’s charges for covered services furnished to the beneficiary, adjusted for cost, are inordinately high. The FI makes cost outlier determinations and pays any outlier amount indicated by its PRICER program **unless the provider indicates a condition code 66**.

The provider should submit the claim as usual, with covered and noncovered days and charges including the applicable noncovered span codes of 74, 76 and 79.

If the beneficiary exhausted benefits during the stay, then the LTCH should follow the instructions as noted in the “benefits exhaust” section previously discussed.

If there are enough benefit days for each medically necessary day in the outlier period, the LTCH will not receive the claim for correction and the FI’s PRICER program will calculate the appropriate payment including the high cost outlier payment.

If there are not enough benefit days for each medically necessary day in the outlier period, the FI will **return** the claim to the LTCH. The FI’s system will instruct the provider of the high cost outlier threshold amount.

The provider then adds the daily covered charges for the claim, determines the day that covered charges reach the outlier threshold amount and places a 47 occurrence code on the claim with the day after the day the cost outlier threshold was reached. The provider must also enter noncovered days and charges on the claim for the days after occurrence code 47 when benefit days exhaust prior to or within the cost outlier period.

Benefits Exhausted with Payable High Cost Outlier

The following two pages contain two benefits exhausted claim examples with payable high cost outliers as they would appear after FI processing.

Examples' Assumptions

1. The high cost outlier threshold amount is \$50,000
2. The threshold amount is reached on the 25th day
3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days
4. Billed charges are \$3,000 per day for the first 12 days, \$2,000 on the 13th day and \$1,000 each day thereafter
5. Beneficiary elects to use any available LTR days

LTCH PPS BILLING

Benefits Not Exhausted with Payable High Cost Outlier

The next three pages are examples, with the same assumptions as the previous three, with **payable** high cost outliers, but **benefits are not exhausted** in these cases:

Examples' Assumptions

1. The high cost outlier threshold amount is \$50,000
2. The threshold amount is reached on the 25th day
3. The DRG average length of stay (ALOS) equals 12 days, therefore, the short stay outlier threshold equals 10 days
4. Billed charges are \$3,000 per day for the first 12 days, \$2,000 on the 13th day and \$1,000 each day thereafter
5. Beneficiary elects to use any available LTR days

LTCH PPS BILLING

1 Long Term Care Hospital (LTCH)	2		3 PATIENT CONTROL NO.				4 TYPE OF BILL 111														
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: 01/01/03 THROUGH: 01/31/03		7 COVD. 30	8 N.C.D. 0	9 C.I.D. 9	10 L.R.D. 21	11													
12 PATIENT NAME Patient # 1-a				13 PATIENT ADDRESS Benefits Available at Admit = 9 co and 60 LTR																	
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES 25 26 27 28 29 30			31								
32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE SPAN FROM THROUGH		39 VALUE CODE CODE AMOUNT			40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT								
42 REV.CD. 012X										43 DESCRIPTION	44 HCPCS RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49					
										PLUS ANCILLARY REVENUE CODES AND CHARGES	500.00		30	15000 00							
														40000 00							
															55000 00						
50 PAYER										51 PROVIDER NO.		52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
										57 DUE FROM PATIENT											
58 INSURED'S NAME					59 P.REL.			60 CERT.-SSN-HIC-ID NO.			61 GROUP NAME		62 INSURANCE GROUP NO.								
63 TREATMENT AUTHORIZATION CODES			64 ESC		65 EMPLOYER NAME				66 EMPLOYER LOCATION												
67 PRIN.DIAG.CD.	68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG.		77 E-CODE		78
12345																					
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 OTHER PROCEDURE CODE DATE		83 OTHER PROCEDURE CODE DATE		84 OTHER PROCEDURE CODE DATE		85 OTHER PROCEDURE CODE DATE		86 ATTENDING PHYS. ID								
84 REMARKS	85 PROVIDER REPRESENTATIVE											86 DATE									
Full LTC-DRG plus cost outlier based on \$55,000 covered charges Cost Report Days = 30	X																				

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

LTCH PPS BILLING

Benefits Exhaust Prior to Admission and Other No-Payment Bills

When a patient does not have any benefits remaining in his/her benefit period and he/she is at a Medicare covered level of care, a claim needs to be submitted to Medicare in order to properly document the continuation of the benefit period.

To bill a claim where Medicare benefits exhaust prior to the stay:

Use TOB 11X

Report all noncovered days

Report any services that cannot be billed under the Part B benefit using 12X TOB

Providers must continue to submit bills for all stays, including those for which no Medicare payment can be made. This assists the FI and CMS in maintaining utilization records and determining remaining eligibility. Even though these bills are noncovered, a bill is required because hospitalization could extend a benefit period.



Hospitals on PPS submit a single bill for a beneficiary's entire stay where no Medicare payment is being made. Therefore, LTCHs on LTCH PPS must be in accordance with the same requirement. The bill is submitted to the FI upon the patient's discharge or death. The provider is not required to send a no-payment discharge bill where the beneficiary is entitled only to Medicare Part B.

Reference:

To view a list of the situations for which no-payment bills are required, providers may refer to the CMS Hospital Manual, Pub.10, Section 411 or Pub. 13, Section 3624. This includes Medicare Secondary Payer (MSP) situations, where the LTCH has received full payment from the primary payer (or an amount considered to be full payment under contractual arrangement or law) and no payment is due from Medicare.

Changes to Chapter 4

The following changes should be made to the claim examples in Chapter 4, LTCH PPS Billing, of the LTCH Training Manual. Please update your manuals accordingly for a more accurate representation of a claim under LTCH PPS:

- 1. Page 93, Form Locator 22-STAT should be 01, not 02.**
- 2. Page 95, Form Locator 22-STAT should be 01, not 62.**
- 3. Page 97, Form Locator 22-STAT should be 01, not 03.**
- 4. Page 104, change \$40,000.00 in charges to \$37,500.00 on the "Plus Ancillary Revenue" line. On the "Total Charges" line, change \$37,500.00 in charges to \$50,000.00.**
- 5. Page 109, Form Locator 13, should contain "Benefits Available at Admit = 15 co and 3 LTR". It is currently blank.**
- 6. Page 116, Form Locator 4-TYPE OF BILL, should be 110, not 111.**