CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 208 **Date: JUNE 18, 2004**

CHANGE REQUEST 3335

I. SUMMARY OF CHANGES: This change request updates the policies for the LTCH PPS for FY 05 based on the May 7, 2004 **Federal Register** in section 150 of Pub. 100-04, chapter 3. It also instructs the FISS system to install and pay claims with the new LTCH PPS Pricer.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/150.4/Revision of the Qualification Criterion for LTCHs
R	3/150.9.1.2/Interrupted Stays
R	3/150.9.1.3/Payments for Special Cases
R	3/150.10/Facility-Level Adjustments
R	3/150.15/ System Edits

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

***Medicare contractors only**

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 208	Date: June 18, 2004	Change Request 3335

SUBJECT: Long Term Care Hospital Prospective Payment System (LTCH PPS) Fiscal Year 2005-Update

I. GENERAL INFORMATION

A: Background: On October 1, 2002, we implemented, through an August 30, 2002 **Federal Register** document, a prospective payment system for LTCHs under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Payments under this system are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. The statute also authorizes the Secretary to examine and provide for appropriate adjustments for payments under the LTCH prospective payment system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment. We are required to update the payments made under this prospective payment system annually.

B. Policy

1. PRICER Updates: For LTCH PPS rate year (RY) 2005, (7/1/04 - 6/30/05)

- the standard Federal rate is $36,833.69
- the fixed loss amount is $17,864.00
- the budget neutrality adjustment is 0.5% (The PRICER payment amount already includes this adjustment.)
- the wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2004 is 3/5th (60 %)
- the labor-related share is 72.885 %
- non-labor related share is 27.115 %
- the short-stay outlier percentage for "subsection II" LTCHs is 193% for this 2nd transition year.

2. Expanding the Existing Interrupted Stay Policy

Under the existing interrupted stay policy, if a LTCH patient is discharged to an acute care hospital, an IRF, or a SNF and then is readmitted to the LTCH within a fixed period of time, the entire LTCH hospitalization, both before and after the interruption will seen as one episode of care, generating one LTC-DRG payment. There is no such policy with regard to LTCH patients discharged and subsequently readmitted if during the interruption they were not inpatients at one of the above inpatient settings. We have revised the interrupted stay policy to include a discharge and readmission to the LTCH within 3 days, regardless of where the

patient goes upon discharge. This means that if a patient is readmitted to the LTCH within 3 days of discharge, Medicare will pay only one LTC-DRG. This policy is intended to cover discharges and readmissions following an outpatient treatment, a 3-day or less inpatient stay, as well as a discharge and readmission with an intervening patient-stay at home. Furthermore Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one exception: for RY 2005 (7/1/04-6/30/05), if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care.

Therefore, any tests or procedures, that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability. If any tests or procedures are delivered any time during the 3-day interruption (with payment being made by the LTCH to the intervening provider under arrangements), all days of the interruption will be included in the total day count for that patient. If no care is provided during the interruption, the days away from the LTCH are not included in the patient stay.

If the interruption exceeds 3 days, LTCH payment will be determined under the original interrupted stay policy (now referred to as a " greater than 3-day interruption of stay ") but the day count for purposes of determining the length of the stay away from the LTCH begins on the day that the patient is first discharged from the LTCH.

NOTE: We will be implementing this policy in a separate CR for January 2005, retroactive for discharges on or after July 1, 2004.

3. Satellite Facilities and Remote Facilities of Hospitals That Spin Off as Separate Hospitals and Seek LTCH Status

We are revising the regulations to specify the CMS policy regarding satellites or remote locations of multi-campus LTCHs becoming independent LTCHs. Such facilities must comply with existing requirements for LTCH designation by first being certified as independent hospitals and then presenting discharge data to their fiscal intermediaries indicating that once they became separate independent hospitals, they met the ALOS requirement for Medicare patients for at least 5 of the next 6 months.

We have established an exception to this policy in situations where the satellite facility or remote location of the hospital is required to become separately certified as a result of failing the mileage requirement of the provider-based regulations. Under the exception, once these satellite facilities or remote locations become separate independent hospitals, they can immediately be paid as a LTCH if they submit to their fiscal intermediaries discharge data gathered during 5 months of the immediate 6 months preceding the facility's separation from the main hospital that document that they meet the ALOS requirement. A satellites that is being "voluntarily" spun-off from a parent LTCH, however, will be paid under the IPPS for at

least 6 months during which time it must gather data to demonstrate that as a hospital, it complies with the ALOS requirement.

4. Determining ALOS based on the number of days of care for only the patients that were discharged during the hospital's fiscal year.

A LTCH's ALOS will be calculated by using days and discharge data for only those patients discharged during the cost reporting period. Therefore, for example, under the proposed policy, for a hospital on a calendar year cost report, the data for the patient that was admitted on 12/15 and discharged on 1/15 would have no impact on the first cost- reporting period, but would include 31 days and one discharge in calculating the ALOS for the second cost-reporting period. Presently, the days and the discharge are reported in the cost reporting period when they occurred, as under the TEFRA system. This change for cases that cross two cost reporting periods would make the methodology for data collection for ALOS purposes consistent with the payment determinations, which under the LTCH PPS, are discharged-based. No LTCH will lose its designation should it fail to meet the ALOS requirement under the new regulations for the first year because of a 1-year grandfathering provision that will allow an extra cost reporting period for compliance. Under this provision, a provider will be permitted to qualify under the previous methodology if it fails to meet the required ALOS under the new methodology.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3335.1	FISS shall install and pay claims with the LTCH PPS Pricer, for discharges on or after July 1, 2004, which includes all CMS updates to RY 2005 changes.	FISS
3335.2	FIs shall ensure that there is a separate provider specific file (PSF) record effective with the start of each provider's cost report period (fiscal year begin date) for every cost report period beginning on or after October 1, 2002. Other PSF data may be updated as needed.	FIs

3335.3	For cost reporting periods beginning during RY 2005, if a provider does not meet the >25 day average length of stay calculation under the new method (days follow the discharge), the FI will evaluate the provider's data using the previous methodology (dividing the days in the year they occurred by the discharges that occurred during that year.)	FIs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3335.2	Pricer pulls the correct wage index based on the fiscal year begin date.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 **Implementation Date:** July 6, 2004 **Pre-Implementation Contact(s):** Judy Richter (policy) at 410-786-2590 and Sarah Shirey (claims) at 410-786-0187 **Post-Implementation Contact(s):** Regional office	**These instructions shall be implemented within your current operating budget.**

150.4 - Revision of the Qualification Criterion for LTCHs

(Rev. 208, 06-18-04)

Under the LTCH PPS, the greater than 25-day average length of stay *(ALOS)* calculation is based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days. For cost reporting periods beginning on or after October 1, 2002, LTCHs are required to meet this revised criteria in order to qualify as LTCHs for Medicare payment purposes.

The average Medicare length of stay is calculated by dividing the total number of covered and noncovered days of care provided to Medicare patients, by the Medicare discharges occurring during that period. *If the days of a stay involve days of care furnished during two or more separate cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future cost reporting period, the total number of days of the stay are considered to have occurred during the cost reporting period during which the patient was discharged. For cost reporting periods beginning on or after July 1, 2004, if a hospital fails to meet the ALOS requirement under this provision, the FI will determine the ALOS for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2005 by dividing the applicable total days for Medicare inpatients during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period*

If the FI determines that the LTCH does not qualify, FIs are to follow the procedures already established in the Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01). The new manual can be found at http://cms.hhs.gov/manuals/cmsindex.asp.

The CMS requires on-going monitoring of LTCH compliance with the above requirements as well as notification by FIs regarding this compliance.

150.9.1.2 - Interrupted Stays

(Rev. 208, 06-18-04)

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at a LTCH during which beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one limited exception: for RY 2005 (July 1, 2004 through June 30, 2005) if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Any tests or procedures, that were administered to the patient during that period of time of interruption, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the3-day or less interruption (e.g., the patient is home and doesn't receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for "under arrangements," all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

- *The original interrupted stay policy is now defined as "a greater than 3-day interruption of stay" and is a* ***stay*** in which a LTCH patient that is admitted upon discharge to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or swing bed and returns to the same LTCH within a specified period of time. The day count begins on the day of discharge from the LTCH, which is also the admission day to the other provider, and ends on the day of readmission to the LTCH.
    - *For an acute care hospital*: *between 4 and 9 consecutive days;*
    - For an IRF*: between 4 and 27 consecutive days;*
    - For a SNF*: between 4 and 45 consecutive days;* and

- For a Swing Bed: *between 4 and 45 consecutive* days or less.

Note that although the greater than 3-day interruption of stay policy only governs when a patient is away from the LTCH for between 4 days and the applicable provider threshold, the day count for determining whether the threshold is met begins when the patient is discharged. So if a patient is discharged on 9/2/04, the 3-day or less interrupted stay policy will govern payment if the patient is readmitted to the LTCH on 9/2, 9/3, or 9/4. If the patient is readmitted to the LTCH on 9/5, payment will be paid to, for example, the acute care hospital which provided treatment, but the day count for determining whether the or not the stay is one interrupted stay or a whether the return to the LTCH is a separate admission starts on 9/2. For example, if the LTCH discharges a patient to an acute care hospital on 9/2/04, if they are readmitted to the LTCH by 9/10/04, this is an interrupted stay. If they are readmitted on 9/11/04, it counts as a separate admission. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made. (The bill generated by the original stay in the LTCH should be cancelled by the provider or they may do a debit/credit adjustment.)

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.

If the length of stay at the "receiving" site of care exceeds the above- specified period of time, the return to the LTCH is a new admission. This means that the original discharge to that site is treated as a discharge for payment purposes.

For the percentage of payments that are to be made under the TEFRA system during the 5-year transition, the FI treats each segment of the interrupted stay as a separate discharge. (FIs are to follow the same procedure as provided under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

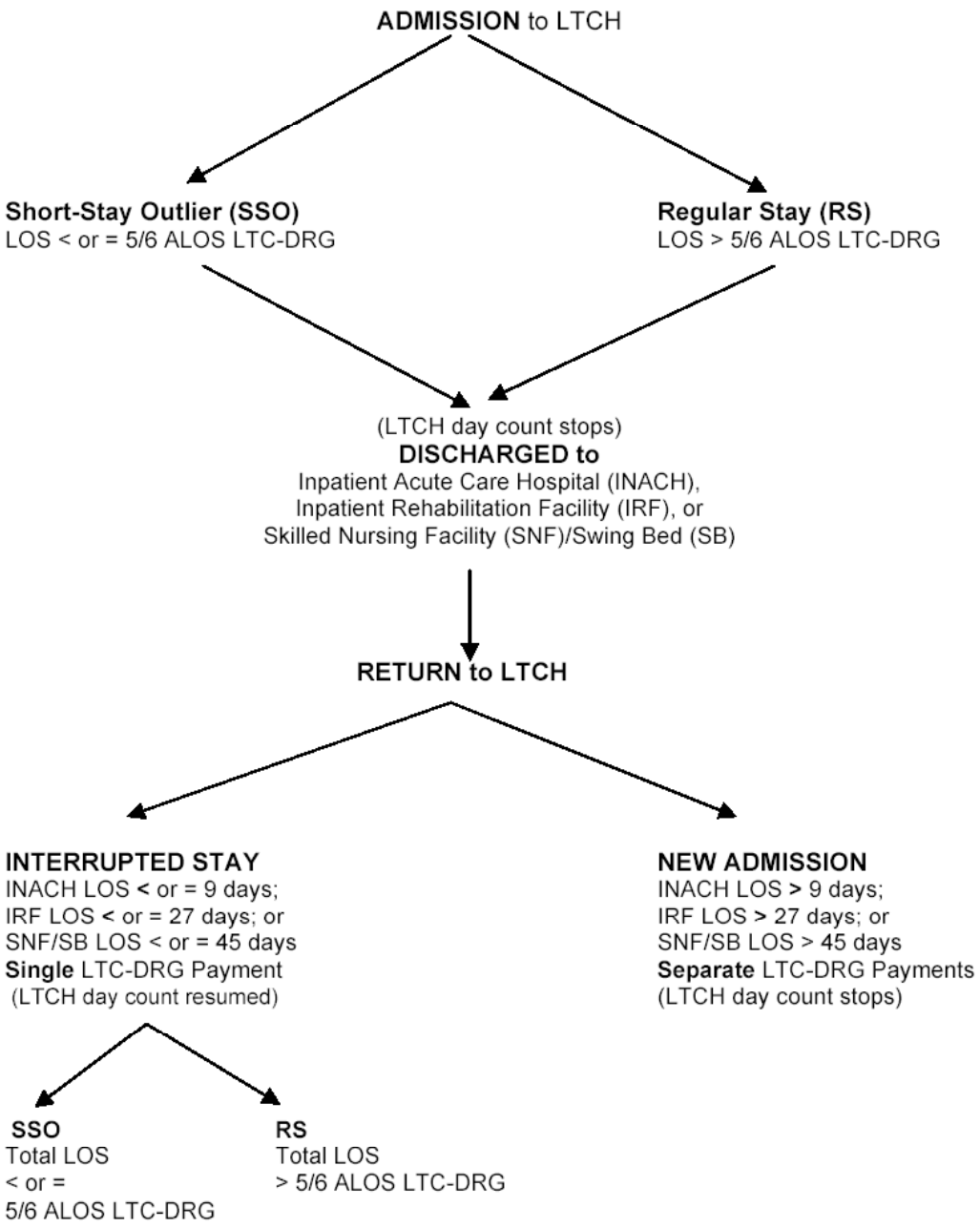
150.9.1.3 - Payments for Special Cases

(Rev. 208, 06-18-04)

- 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 following flow chart describes the order that is used to assess whether or not the adjustments apply. For example, a case may be a short-stay outlier and also be *governed by either the 3-day or less or greater than 3-day interruption of stay policy and therefore only generate 1 LTC-DRG payment to the LTCH.*

SHORT-STAY OUTLIERS AND INTERRUPTED STAYS



150.10 - Facility-Level Adjustments

(Rev. 208, 06-18-04)

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 include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

- The system includes an area wage adjustment that is being phased in over 5 years.
- The wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.
- A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under §§1886(d)(8) - (10) of the Act.
- The phase-in of the wage index adjustment is as follows:

Cost Reporting Periods Beginning During	**Applicable Wage Index Value**
FY 2003	1/5th of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2004	2/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2005	3/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2006	4/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2007	Full value (5/5^{ths}) of the value of the applicable pre-reclassification, no floor

Cost Reporting Periods Beginning During	Applicable Wage Index Value
	hospital inpatient wage index

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 is no empirical evidence to support other adjustments. Therefore, for the present, there are no adjustments for DSH, IME, or geographic reclassification.

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 acute care hospital inpatient PPS).
- *Annual updates for the LTCH PPS appear in **Federal Register** publications: for payment rates and associated adjustments, see the LTCH PPS final rule with an effective date of July 1. Annual updates of the LTC-DRGs are published in the IPPS final rule with an effective date of October 1.*
- The COLA factors effective *July 1, 2004* are the same as under the Acute Care Hospital Inpatient PPS and are as follows:

Area	COLA
Alaska:	
All Areas	1.25
Hawaii:	
Honolulu	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

150.15 - System Edits

(Rev. 208, 06-18-04)

The Shared systems and/or Common Working File (CWF) must ensure:

- That revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- That the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;
- That Occurrence Span Code 74 FL36, (RT 40, fields 22,24,26), (2300 loop HI code BI), is present on the claim when there is an interrupted stay (the beneficiary has returned to the LTCH in a specified amount of time). *See section 150.9.1.2.*

If the interruption is greater than the specified number of days applicable to the specific provider, the bill is considered a discharge and two bills would exist if the beneficiary returns to the same LTCH, otherwise it is considered an interruption with one DRG payment associated. CWF will edit for both of these situations.

Payments under the onsite discharge and readmittance policy are to be reconciled at cost report settlement, at which time it is possible to determine the total number of such cases that have occurred during that cost reporting period.

The accommodation revenue code 018X (RT 50, field 5), (SV 201), (leave of absence) continues to be used in the current manner in terms of Occurrence Span code 74 (RT 40, field 22 - 27) and date range.