Program Memorandum Intermediaries

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

Transmittal A-02-093 **Date: SEPTEMBER 27, 2002**

CHANGE REQUEST 2288

SUBJECT: Instructions for Implementing the Long-Term Care Hospital Prospective Payment System

The purpose of this Program Memorandum (PM) is to provide general information and specific instructions related to the implementation of the Medicare prospective payment system for long-term care hospitals (LTCHs). This PM is divided into three sections. The first section consists of background material, the second describes the payment policies included in the LTCH PPS final rule published in the August 30, 2002 **Federal Register** (67FR 55954), and the third provides the claims processing and billing instructions.

Background

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. This PPS would replace the existing reasonable cost-based payment system under which the LTCHs are currently paid.

Statutory Requirements:

- The Balanced Budget Refinement Act (BBRA of 1999, as amended by the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA of 2000), requires 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 Tax Equity and Fiscal Responsibility Act (TEFRA) payment system.

- In the event that the Secretary is unable to implement a PPS by October 1, 2002, the statute requires an implementation of a PPS using the "existing hospital DRGs, modified where feasible" to account for differences in resource use by LTCHs.

CMS has satisfied the statutory implementation requirement by establishing October 1, 2002 as the effective date of the LTCH PPS with systems changes to follow. Payments for LTCH services delivered for cost reporting periods starting on or after October 1, 2002 will be based on the policies set forth in the August 30 final rule (67 FR 55954).

Affected Medicare Providers:

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

days. LTCHs are identified by the last 4 digits of the Medicare provider number, which range between **"2000" and "2299"**.

- Currently the average length of stay is based on all of the hospital's inpatients (both Medicare and non-Medicare).
- Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U. S. C. 1395b-1) or §222(a) of Public Law 92-603 (42 U. S. C. 1395b-1) are not included in the LTCH PPS. Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c).
- Two of the four Maryland LTCHs included on CMS' OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore 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).
- As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), Fiscal Intermediaries (FIs) are authorized to conduct medical review (MR) of LTCH PPS claims notwithstanding the agreements required between LTCHs and QIOs, under the LTCH PPS, for admission and quality review. All FI's are required to conduct data analysis to identify potential errors and prioritize workload. If an identified aberrancy becomes a priority within the contractor's MR strategy contractors will institute progressive corrective action concepts (PCA).

Revision of the Qualification Criterion for LTCHs:

- Under the PPS, the 25-day calculation will be 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 must meet this revised qualification established under the LTCH PPS that counts only Medicare patients in the average 25-day LOS calculation. The FI will review the LTCH's discharge data from the most recent complete cost reporting period following the effective date of the PPS and will notify the LTCH if it satisfies the new criteria. The LTCH becomes subject to this new criterion for its first cost reporting period beginning on or after October 1, 2002. 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.

- We will be requiring on-going **monitoring and notification by FIs** regarding LTCH compliance following these procedures.

- 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.

PAYMENT PROVISIONS UNDER LTCH PPS

Section 123 of Public Law 106-113, the BBRA of 1999, as amended by §307 of Public Law 106-554, the BIPA of 2000, authorizes the establishment of Federal payment rates under 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.

- Budget Neutrality:
  - The BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.
  - Budget Neutrality Offset
    - A reduction factor to **all** Medicare payments during the transition to account for the monetary effect of the 5-year transition from the present cost-based payment system and the PPS and the policy to permit LTCHs to elect payment solely under the PPS rather than based on the blend during the transition.
    - If a LTCH is paid under the transition blend methodology (discussed in the Facility-Level Adjustments section below), the budget neutrality offset will be applied to **both** the TEFRA Rate Percentage and the Federal Rate percentage.
    - The budget neutrality offset equals 1 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 and the option to elect payment based on the 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.
  - The per discharge Federal rates under the PPS will be based on average LTCH costs in a base year updated for inflation to the first effective period of the system.

- The PPS will be updated annually as is done with the inpatient, IRF, and SNF/Swingbed PPS systems.

Beneficiary Liability

- Beneficiary liability will operate the same as under the current TEFRA payment system, i.e., even if Medicare payments are below cost of care for a patient under prospective payment, the patient cannot be billed for the difference.

- As under the present TEFRA payment system, beneficiaries (or their Medigap insurance or other private insurance, such as an employer-sponsored plan, as applicable) are responsible for all non-covered days, where Medicare has not made a full LTC-DRG payment.

- Once a stay triggers a full LTC-DRG payment (i.e., it exceeds the short-stay outlier threshold described on p. 4), Medicare's payment is for the entire stay up to the high cost outlier threshold, regardless of patient coverage. But for lengths of stay equal to or below $5/6^{th}$ of the average length of stay for a specific LTC-DRG, Medicare's payment is only for covered days.

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* Presently, each LTCH is paid on a hospital-specific basis under the TEFRA payment system. When the PPS is totally phased-in, after the 5-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a "Federal payment rate."

- For a 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 (under the short-stay policy). If the patient has 27 days remaining of Medicare coverage and stays for 26 days, Medicare would pay a full LTC-DRG. In this scenario, the patient's length of stay exceeded the short stay outlier threshold and the patient also had sufficient Medicare covered days to generate a full LTC-DRG payment, which would constitute Medicare payment until and unless the stay had become a high cost outlier.

Once the beneficiary exceeds the 5/6th 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 may have already reached the 90th regular Medicare covered day within the benefit period. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the lifetime reserve days. The beneficiary has no coinsurance (or any other) liability for the gap between the 90th day and the start of lifetime reserve days.

- Policy regarding the use of lifetime reserve days is the same as under the IPPS. 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 against 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 life-time 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.

- 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 life-time reserve days for the period (or portion) of the stay beyond the high cost outlier threshold, i.e.,:

  - Beneficiary "A" is admitted to the LTCH with 26 remaining days of regular Medicare coverage and is grouped to a LTC-DRG with an ALOS of 30 days. On the 26th day of that stay, "A" has sufficient regular benefit days to trigger a full LTC-DRG payment (greater than 5/6th 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 continue and ultimately 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 as a private pay patient) and the day count will continue, uninterrupted, until the patient is either discharged or the days are exhausted.

Patient Classification System:

The BBRA required the use of diagnostic-related groups (DRGs) for patient classification purposes in the PPS for LTCHs. In general, a case will be grouped based on the clinical characteristics of the Medicare beneficiary.

- The patient classification system groupings are called **LTC-DRGs**, which are based on the existing CMS DRGs used under the hospital inpatient PPS.
  - Patient discharges would 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.
  - The same GROUPER software developed by 3M for the hospital inpatient PPS, will be used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.
    - Version 20 hospital inpatient PPS GROUPER (FY 2003) will be used for FY 2003.

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

- Relative weights and the geometric average length of stay are in the PRICER program.

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 (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 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.
    - The formula for an unadjusted LTCH PPS prospective payment is:

Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate

Case-Level Adjustments

Payments will be based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments will be applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

- Short-stay outliers:
  - A short-stay outlier is a case that has a length of stay between 1 day and up to and including 5/6 of the average length of stay 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 (determined using the facility-specific cost to charge ratio and covered charges from the bill);
- 120 percent of the LTC-DRG specific per diem payment (determined using the LTC-DRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or
- The full LTC-DRG payment.

i.e.,
To compute 120% of cost:

Charges x CCR = Cost
($13,870.33) x (0.8114) = $11,254.39
120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

Full LTC-DRG payment:

$34,956.15 (standard Federal rate)
x 0.72885 (labor %)
$25,477.79 (labor share)
x 1.0301 (1/5th wage index value)
$26,244.67 (wage adjusted labor share)
+ 9,478.36 (non-labor share=$34,956 x 0.27115)
$35,723.03 (adjusted standard Federal rate)
x 1.4103 (LTC-DRG 113 relative weight)
$50,380.19 (full LTC-DRG payment

Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this 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).

- Interrupted stays:
  - An interrupted stay is a case in which a LTCH patient that is transferred 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.
    - For an acute care hospital: 9 days or less
    - For an IRF: 27 days or less
    - For a SNF: 45 days or less, and
    - For a Swing Bed: 45 days or less.

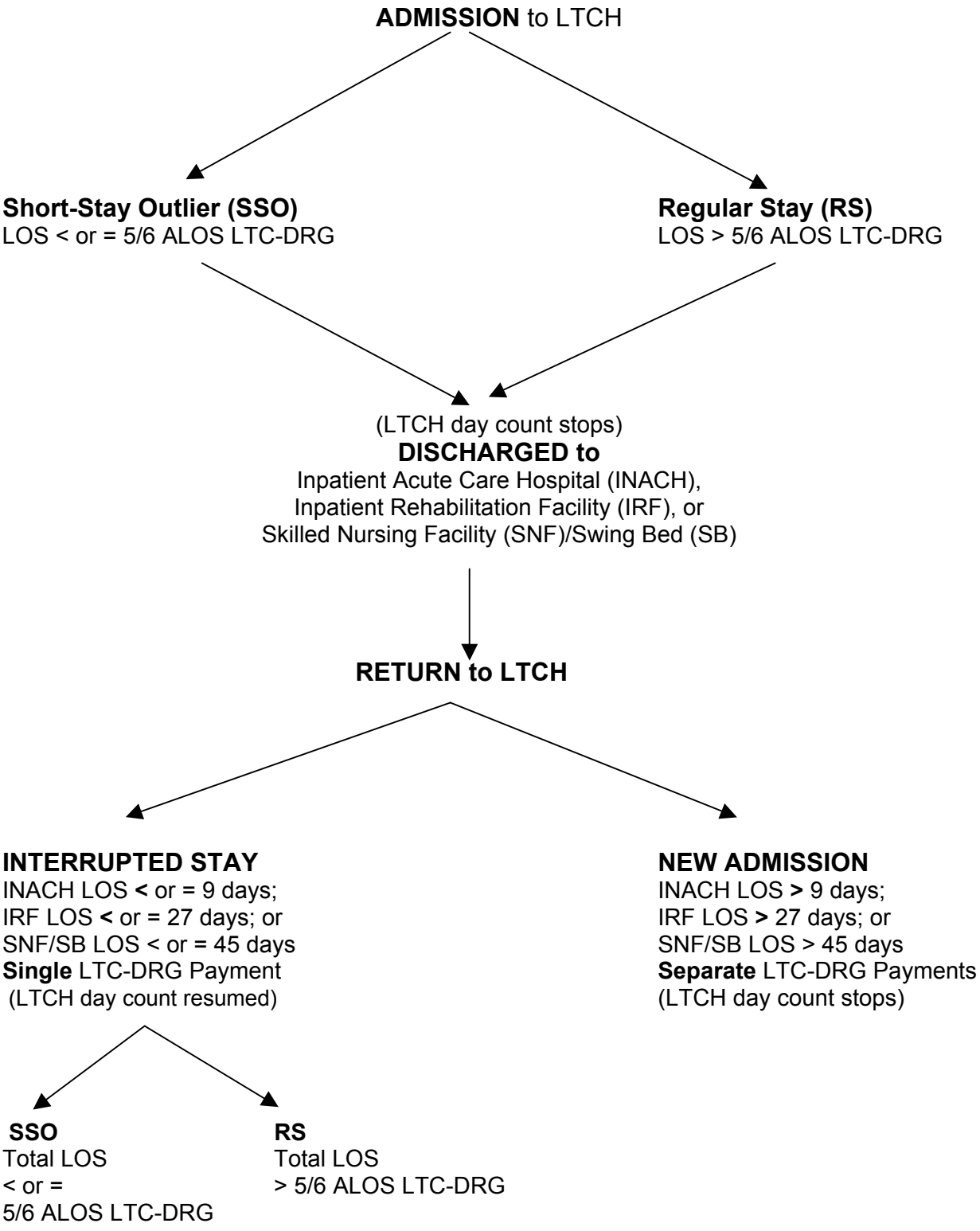
    i.e., if the LTCH discharges a patient to an acute care hospital on 9/2/02, if they are readmitted to the LTCH on 9/10/02, this is an interrupted stay. If they are readmitted on 9/11/02, it counts as a separate admission.
  - An interrupted stay case is treated as one discharge for the purposes of payment; 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 will be a new admission. This means that the original transfer to that site will be treated as a discharge for payment purposes.
- For the percentage of payments that will be made under the TEFRA system during the 5-year transition (see p. 7), 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.)

- Payments for special cases:
  - 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



- There are no special payment policies for transfer cases or deaths, i.e., if a patient in LTCH "A" is transferred 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.

- Payment policy for co-located providers (hospitals within hospitals, satellite facilities, and on site SNFs):
  - For on-site acute care hospitals: if during a cost reporting period, a LTCH readmits more than 5 percent of its patients who were discharged to an onsite acute care hospital, only one LTC-DRG payment (with adjustments made for length of stay, as necessary) would be made to the LTCH for all such discharges and readmittances during that cost reporting period.
  - For on-site SNFs, IRFs or psychiatric facilities: if during a cost reporting period, more than 5 percent (separate from the 5 percent for acute care hospitals) of the LTCH patients are discharged to an on-site SNF, 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.
  - 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. 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 RO of such arrangements.
  - Payments under this policy will be determined at cost report settlement. Further instructions will be forthcoming.

- High Cost Outlier Cases
  - Additional payments will be made for those cases that are high cost outliers. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). (Short-stay outliers, described above, are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short-stay outlier cases.)
  - The fixed loss amount is determined such that projected outlier payments are equal to 8 percent of total LTCH PPS payments.
  - The fixed loss amount for FY 2003 is $24,450.
  - If the estimated cost of the case is greater than the outlier threshold an additional payment will be added to the LTC-DRG payment amount.
  - The outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).
    - The estimated cost of the case will be calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

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 include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).
  - The system will include an area wage adjustment that will be phased in over 5 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 FY 2003, the labor-related share of the standard Federal rate is 72.885 percent.
  - 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 sections 1886(d)(8) – (10) of the Act.
  - For FY 2003, the wage index value is $1/5^{th}$ of the value of the pre-reclassification, no floor 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 was no empirical evidence to support other adjustments. Therefore, there will be no adjustment for DSH, IME, or geographic reclass.
- 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.
  - The COLA factors for FY 2003 are the same as under the Hospital Inpatient PPS and are as follows:

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

- <u>Phase-in Implementation</u>
  - The PPS for LTCHs will be phased-in over **5 years** from cost-based reimbursement to Federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's 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 through September 30, 2003	20	80
October 1, 2003 through September 30, 2004	40	60
October 1, 2004 through September 30, 2005	60	40
October 1, 2005 through September 30, 2006	80	20
October 1, 2006	100	0

- LTCHs may exercise a one-time 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 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.
- Payments to new LTCHs, i.e., a hospital that has its first cost reporting period as a LTCH beginning on or after October 1, 2002, are made based on 100 percent of the standard 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 TEFRA portion of transitions payments.

Requirements for Provider Education and Training

Empire Blue Cross/Blue Shield, on behalf of CMS, has developed training resources for fiscal intermediary (FI) staff to use in training providers about the Long Term Care Hospital Prospective Payment System (LTCH PPS). The train-the-trainer process for LTCH PPS will not include in-person instruction for FIs. Instead, CMS will provide various educational resources for FIs to learn about LTCH PPS. In turn, FIs who have LTCHs in their service area whose new cost reporting year begins on January 1, 2003 are required to complete provider training no later than December 6, 2002. Providers who are transitioning to the LTCHPPS system after January 1, 2003 should be trained at least 30 days before the transitioning date.

CMS is providing the following LTCH PPS education resources for FIs:

- A training guide is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp
- A training video has been mailed to FIs
- A PowerPoint presentation for training providers is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp
- An e-mail mailbox has been established to address your questions. Send questions to: LTCHPPS@cms.hhs.gov

If you have questions regarding FI training, contact Suzanne Lewis at (410) 786-7636.

CLAIMS PROCESSING AND BILLING

Processing Bills Between 10/1/02 and the Implementation Date

Claims submitted prior to implementation will be processed under the current methodology. On or after January 1, 2003, mass adjust claims under the PPS payment methodology by April 30, 2003**.** The standard systems will create a mass adjustment program.

- We will not have in place before January 1, 2003, the standard computer systems changes necessary to accommodate claims processing and payment under the LTCH PPS. 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 to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding. All ICD-9-CM coding must be used for LTCH providers with cost reporting period beginning on or after October 1, 2002.

Billing Requirements Under LTCH PPS

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs must incorporate the following so that Fiscal Intermediaries (FIs) can accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for LTCHs are from 2000 to 2299.

- This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of 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 on the claim. Grouper 20.0 will determine DRG assignment.

- There has been a major problem with MedPAR data and **multiple billing**. Each bill from a LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Coding instructions regarding this will be included in provider training materials. Normal adjustments will be allowed.

LTCH providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

Stays Prior to and Discharge After PPS Implementation Date

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under LTCH PPS, payment to the facility is based on LTCH PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (according to §3603 A of the Medicare Intermediary Manual (MIM)). If the facility submits multiple interim bills, the provider will need to submit cancels for all bills and then rebill once the cancels are accepted.

Note: For LTCH providers with PPS transition dates prior to the implementation of the systems 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 sections above.

- LTCHs can submit adjustment bills, but late charge bills will not be allowed, like in inpatient and IRF PPS.

- All patient status i.e. discharge disposition codes for 11X Type of Bill are valid, but there are no special payment policies related to transfers; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with Condition Code 40) are applicable under LTCH PPS.

- Regarding patient status codes and benefit application, there are no changes to the way it is currently handled under IPPS.

- LTCHs will be paid under the LTCH PPS beginning on the first day of their cost reporting period that begins on or after October 1, 2002.

System Edits

The Standard 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) and the beneficiary was transferred upon discharge to:

    - An acute care hospital-(Patient Status Code 02) in 9 days or less,
    - an IRF-(Patient Status Code 62) in 27 days or less,
    - A SNF-(Patient Status Code 03) 45 days or less, and
    - A Swing Bed (Patient Status Code 61) 45 days or less

    - 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 do the editing for both of these situations.

    - Payments under the onsite discharge and readmittance policy will be reconciled at cost report settlement, at which time it will be 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) will continue to be used in the current manner in terms of Occurrence Span code 74 (RT 40, field 22 – 27) and date range.

- Patient Status code 63 must be removed from CWF edit 7111 and alert 7531.

Billing Ancillary Services Under LTCH PPS

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- LTCHs are required to report the number of units in FL 46 based on the procedure or service.

- LTCHs are required to report the actual charge for each line item, in Total Charges, FL 47.

- In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS. Refer to MIM §3626.1.

Benefits Exhausted

If a beneficiary's Part A benefits exhaust during the stay, code an Occurrence Code A3-C3 (RT 40, field 8-21), (2300 loop HI code BH). If benefits are exhausted prior to the stay, submit a no-pay claim that will be coded by the FI with no pay code B.

LTCH PPS uses Occurrence Code 47 to indicate the first full day of cost outlier status and also uses Occurrence Span Code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

The following examples illustrate the short-stay outlier policy in relation to benefits exhausted:

Assumptions:

1. Cost outlier threshold amount is $50,000
2. Threshold amount is reached on the 25th day
3. The DRG ALOS equals 12 days, therefore, the Short Stay 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

Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)

1a.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 9 coinsurance and 60 LTR
Covered days: 30
Noncovered days: 0
Coinsurance days used: 9
LTR days used: 21
Cost report days: 30
Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

1b.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $27,000
Benefits available: 9 coinsurance and 0 LTR
Covered days: 9
Noncovered days: 21
Coinsurance days used: 9
LTR days used: 0
Cost report days: 9

OC A3: 1/09/03
Reimbursement: Short stay outlier

1c.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $50,000
Benefits available: 9 coinsurance and 10 LTR
Covered days: 19
Noncovered days: 11
Coinsurance days used: 9
LTR days used: 10
Cost report days: 25
OC 47: 1/26/03
OC A3: 1/25/03
OSC 70: 1/20/03 – 1/25/03
Reimbursement: Full DRG payment

Example 2: Coinsurance Days ≥ Short Stay Outlier Threshold (30 day stay)

2a.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 15 coinsurance and 60 LTR
Covered days: 20
Noncovered days: 10
Coinsurance days used: 15
LTR days used: 5
Cost report days: 30
OC 47: 1/26/03
OSC 70: 1/16/03 – 1/25/03
Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

2b.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $53,000
Benefits available: 15 coinsurance and 3 LTR
Covered days: 18
Noncovered days: 12
Coinsurance days used: 15
LTR days used: 3
Cost report days: 28
OC 47: 1/26/03
OC A3: 1/28/03
OSC 70: 1/16/03 – 1/25/03
Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

2c.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $50,000
Benefits available: 15 coinsurance and 0 LTR
Covered days: 15
Noncovered days: 15
Coinsurance days used: 15
LTR days used:0
Cost report days: 25
OC 47: 1/26/03
OC A3: 1/25/03
OSC 70: 1/16/03 – 1/25/03
Reimbursement: Full DRG payment

Example 3: Coinsurance Days ≥ Short Stay Outlier Threshold (20 day stay)

Date of service: 1/1/03 – 1/21/03
Medically necessary days: 20
Covered charges: $45,000
Benefits available: 15 coinsurance and 0 LTR
Covered days: 15
Noncovered days: 5
Coinsurance days used: 15
LTR days used: 0
Cost report days: 20
OSC 70: 1/16/03 – 1/20/03
Reimbursement: Full DRG payment

Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)

Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $27,000
Benefits available: 9 LTR
Covered days: 9
Noncovered days: 21
Coinsurance days used: 0
LTR days used: 9
Cost report days: 9
OC A3: 1/09/03
Reimbursement: Short stay outlier payment

Example 5: Only LTR ≥ Short Stay Outlier Threshold (30 day stay)

5a.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $50,000

Benefits available: 12 LTR
Covered days: 12
Noncovered days: 18
Coinsurance days used: 0
LTR days used: 12
Cost report days: 25
OC 47: 1/26/03
OC A3: 1/25/03
OSC 70: 1/13/03 – 1/25/03
Reimbursement: Full DRG payment

5b.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 60 LTR
Covered days: 30
Noncovered days: 0
Coinsurance days used: 0
LTR days used: 30
Cost report days: 30
Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

5c.
Date of service: 1/1/03 – 1/31/03
Medically necessary days: 30
Covered charges: $53,000
Benefits available: 28 LTR
Covered days: 28
Noncovered days: 2
Coinsurance days used: 0
LTR days used: 28
Cost report days: 28
OC 47: 1/26/03
OC A3: 1/28/03
Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

PIP

PIP applies to this PPS. Outlier payments in regards to PIP will be handled the way they currently are under other inpatient PPS systems.

Interim Billing

Interim bills are allowed every 60 days. If the facility submits multiple interim bills, the provider must cancel and rebill once the cancels are accepted. See §3603A of the MIM for instructions on interim billing.

IBPR Report

The IBPR report will change to reflect the payments for LTCHs going to PPS free-standing hospitals.

Monitoring

Additional instructions for monitoring the implementation of LTCH PPS through Pulse are as follows:

- Fiscal Intermediary Standard System (FISS) Changes:

  The FISS 620A and 620B reports will be modified to add an additional row for LTCH monitoring. The report will be modified to include a separate reporting line titled "LTCH PPS." This entry will appear immediately below "IRF PPS" and report the total claim count and total reimbursement amount. LTCH PPS totals will include all providers with the last four digits of the provider numbers in range 2000-2299.

- Arkansas Part A Standard System (APASS) Changes:

  The APASS M70094C report will be modified to add an additional row for LTCH PPS monitoring. This new row will be for bill type 11 and description "INPATIENT LTCH". This new row will appear directly below bill type 11 "INPATIENT IRF." Like all of the other rows the INPATIENT LTCH line will only appear on the report when there is data to report. If no INPATIENT LTCH claims were paid, this line will not appear on the APASS M70094C report. LTCH PPS totals will include all providers with the last four digits of the provider numbers in range 2000-2299.

Remittance Advices

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

Medicare Summary Notices and Explanation of Medicare Benefits

Use existing notices for inpatient hospital PPS for LTCH PPS.

LTCH Pricer Software

- CMS has developed a LTCH PRICER program that calculates the Medicare payment rate. PRICER software will be electronically supplied to the Standard Systems. Instructions for updating the provider specific data for LTCH PPS will appear in §3656.3 and §3850 of the MIM.

  - Pricer will pay a short-stay outlier if the stay is between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG.

  - Pricer will incorporate the five-year phase-in period for those providers that choose to be paid on the blended rate.

Inputs/Outputs to PRICER

Inputs

- Provider Specific File Data (to be updated in§§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%), 21,22,25 (although this field refers to the operating cost/charge ratio, for LTCH, entered here will be a combined operating and capital cost/charge ratio). See the section "Determining the Cost-to-Charge Ratio" of this instruction below for determining the cost/charge ratio.
- The facility-specific rate (Field 21) 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 were not being implemented.
- Bill Data
    - Provider #
    - Patient Status
    - Covered Charges
    - Discharge Date
    - Length of Stay (LOS)
    - Covered Days
    - Lifetime Reserve Days (LTR)
    - DRG (from Grouper)

Outputs

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

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.

Fiscal intermediaries will :

- use the latest available settled cost report and associated data in determining each LTCH's overall Medicare cost-to-charge ratio.

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

- 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.

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 Hospital Impatient PPS 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 Hospital Inpatient PPS 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.

To ensure that the distribution of outlier payments remains equitable, a 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.

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.

Under the LTCH PPS, an overall Medicare cost-to-charge ratio 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.

The *effective date* for this PM is October 1, 2002.

The *implementation date* for this PM is January 6, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate intermediary.