CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 267 **Date: JULY 30, 2004**

CHANGE REQUEST 3391

NOTE: This CR is no longer Sensitive and can be posted to the Intranet and Internet.

SUBJECT: Crossover Patients in New Long Term Care Hospitals (LTCH)

I. SUMMARY OF CHANGES: This CR seeks to implement a new payment policy for new Long Term Care Hospitals who have "crossover" patients. We are also updating the Chapter 3 of the manual with this new policy.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: January 3, 2005

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: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/100.4.1/Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number
N	3/150.14.1/Crossover Patients in New LTCHs

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

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

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

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SUBJECT: Crossover Patients in New Long Term Care Hospitals (LTCH)

I. GENERAL INFORMATION

A. Background: When a hospital changes designation and provider number, the policy has been to discharge the patient under the "old" provider number and readmit the patient under the "new" provider number (Pub. 100-04, Chapter 3, section 100.4.1). This has resulted in two payments to a facility for the same patient.

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to a LTCH, payment issues arise for "cross-over" patients who were admitted prior to the change in classification who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as hospitals and generally be paid under the IPPS, for 6 months prior to designation as a LTCH, in 42 CFR 412.23(e), there are "cross-over patients," at the creation of every LTCH, who were admitted to the facility when it was an acute care hospital. Medicare pays twice for what was really one episode of care since separate payment is made to both the acute hospital and the LTCH. We are establishing a consistent policy for such situations to avoid this and therefore, Medicare will issue one discharge-based payment to the hospital that discharges the patient, under the applicable payment system.

This policy is effective for new Long Term Care Hospitals on or after October 1, 2004.

B. Policy: In the regulations at 42 CFR 412.521(e) we provide a payment methodology for such cases in which Medicare will consider all the days of the patient stay in the facility (both prior to and following the date of LTCH designation) to be a single episode of LTCH care. Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Furthermore, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3). This policy applies only to a patient stay in an acute care hospital that is designated as a LTCH on or after October 1, 2004.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at 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. Contractors are free to supplement Medlearn Matters articles

with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (place an “X” in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3391.1	FIs shall ensure that this payment policy shall apply to new LTCHs certified on or after October 1, 2004.	X								
3391.1.1	FIs shall pay under LTCH PPS by allowing the “from” date of a LTCH bill to occur before the effective date of the LTCH and the “through” date to be after the effective date for new LTCHs with crossover patients.	X								
3391.1.2	FISS shall create a crosswalk to link a new LTCH’s provider file to the previous IPPS provider file.					X				
3391.1.3	FIs shall update the crosswalk for every new LTCH.	X								
3391.1.4	FISS shall allow end user at FI ability to see that LTCH is related to IPPS hospital.					X				
3391.1.5	FIs shall reject as provider liable incoming LTCH bills if there are any paid IPPS bills in history from the crosswalk IPPS provider for the same episode of care (i.e., the same admission date or through date of IPPS claim matches the date of the LTCH claim) and IPPS discharge is same day as effective date of LTCH.	X								

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3391.2	FIs shall determine if claims submitted by new LTCHs (new on or after October 1, 2004) have been billed correctly for crossover patients and reprocess and reject within 30 days of the implementation of this CR if determined to not have been billed correctly (i.e., IPPS bills cancelled so that true admission date is on LTCH bill).	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3391.1.5	Remittance Advice message: N47-claim conflicts with another inpatient stay. MSN Message: 41.14-the item/service billed incorrectly

C. Interfaces: Provider Specific Files

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2004 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Sarah Shirey (Claims Processing), email sshirey@cms.hhs.gov or Judy Richter (LTCH payment policy), email jrichter@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 267, 07-30-04)

100.4.1 - Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number

(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

Where a multiple-facility provider is assigned separate provider numbers for each component facility or where a provider is assigned a different number, it is required to use the new number for all notices of admission, start of care notices, bills, etc., beginning with the date the new number is effective.

A - Inpatient

The component provider to which the new number is assigned must apportion costs for all patients who are inpatients in that component as of the first day of the next fiscal period when the new provider number goes in effect. The hospital must submit a discharge bill with the old provider number and an admission notice with the new. The date of discharge and the date of admission are the same date, which is the first day of the new fiscal period. All subsequent billings are submitted under the new provider number. If a no-payment situation where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit a discharge bill and admission notice. In this situation, only a final no-payment bill with a discharge date is submitted under the old provider number. Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished **before** the date of change in provider number, the hospital submits one corrected bill covering the entire period showing the old provider number. However, where services subsequently determined to be covered were furnished **after** the date of change, the hospital submits a corrected discharge bill with the old provider number and a new admission notice and billing with the new provider number.

Effective October 1, 2004, there are new rules pertaining to long term care hospitals. (See section 150.14.1).

B - Outpatient Services, Part B Ancillary Services and Home Health Agency Services

For outpatient services and Part B ancillary services, and home health agency services, the provider uses the old provider number for services provided up through the day before the effective date of the new provider number. Thereafter, it uses the new number when submitting bills.

150.14.1 Crossover Patients in New LTCHs

(Rev. 267, Issued 07-30-04, Effective: 10-01-04, Implementation: 01-03-05)

When a hospital undergoes a change in ownership or a change in classification from an acute care hospital to a LTCH, payment issues arise for "cross-over" patients who were admitted prior to the change in classification who are still hospitalized under the new provider number. Since all LTCHs are required to be certified as hospitals and generally be paid under the IPPS, for 6 months prior to designation as a LTCH, in 42 CFR 412.23(e), there are "cross-over patients," at the creation of every LTCH, who were admitted to the facility when it was an acute care hospital. The policy was to discharge the patient under the acute provider number and readmit the patient under the new LTCH provider number (see section 100.4.1 of this chapter). Medicare paid twice for what was really one episode of care since separate payment would be made to both the acute hospital and the LTCH. Effective October 1, 2004, Medicare will issue one discharge-based payment to the LTCH that discharges the patient, under the applicable payment system.

In the regulations at 42 CFR 412.521(e) we provide a payment methodology for such cases in which Medicare will consider all the days of the patient stay in the facility (both prior to and following the date of LTCH designation) to be a single episode of LTCH care. Payment for this single episode of care will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under the LTCH PPS. Furthermore, the days of the patient's stay both prior to and following designation as a LTCH are counted in determining the patient's total length of stay at the LTCH both for payment purposes as well as for the LTCH's average length of stay (ALOS) calculation under 42 CFR 412.23(e)(2) and (3).

Bills paid to the facility for crossover patients when the facility was paid under IPPS must be canceled, so that the entire stay can be billed under the LTCH provider number and paid for under LTCH PPS.