

# Billing

Long Term Care Hospital  
Prospective Payment System

# Billing Objectives

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

# Implementation Schedule

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

# Implementation Schedule (2)

Examples:

<b>Cost Report Period Start Date on</b>	<b>New Coding Applicable to Discharges on and after</b>
10/01/02	10/01/02
01/01/03	01/01/03

# Standard Systems Delay

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



# **Billing Requirements Unchanged By The Implementation Of LTCH PPS**

# Unchanged Requirements

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

# Patient Status Codes

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



# Ancillary Services

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

# Pre-Admission Services

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

# **Adapting Existing IPPS Requirements For LTCH PPS**

# Adapting IPPS Requirements For LTCH PPS

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



# LTR Days - Policy for Use

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



# Full LTC-DRG vs. Short Stay Outlier

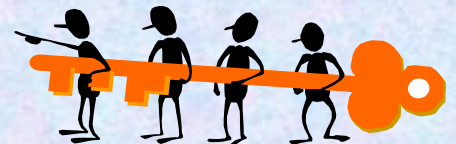
- Full LTC-DRG
  - Patient has enough benefit days to exceed number of days that would categorize case as short stay outlier (exceeds threshold)
- Short stay outlier
  - Patient does **not** have enough benefit days to exceed short stay outlier threshold **or**
  - Patient has enough benefit days, but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

# Benefits Needed For Full LTC-DRG Payment

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

# Short Stay Outlier - Example #1

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



# Short Stay Outlier - Example #2

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



# **New Billing Requirements Under LTCH PPS**



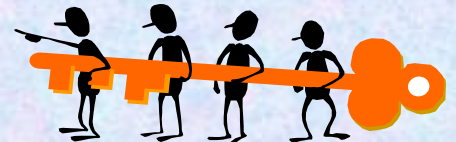
# New Concepts

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

# Billing Frequency

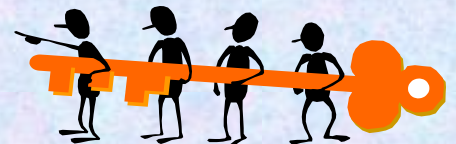
# One Claim Per Stay

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



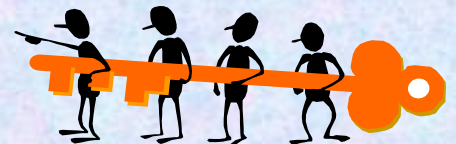
# Interim Billing

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



# Late Charge And Split Billing

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

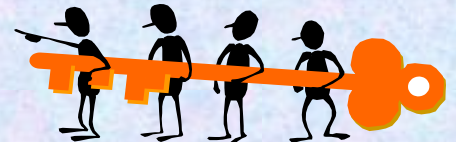




# **Claims Crossing PPS Transition Date**

# Admissions Prior To Transition

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



# Interrupted Stays

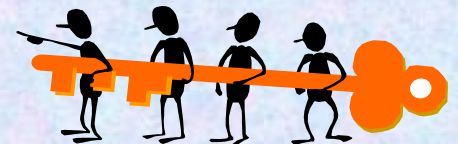
# Interrupted Stays (2)

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

# Fixed-Day Periods

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

Facility Type	Days
Inpatient Hospital	$\leq 9$
IRF	$\leq 27$
SNF / Swing Bed	$\leq 45$





# Example #1-A

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

# Example #2-A

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

# Example #3-A

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

# Multiple Interrupted Stays

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



# Situations That Are Not Interrupted Stays

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



# LTCH LOS Determines Payment Policy

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

# LTCH LOS Determines Payment Policy Payment

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

# Submitting Interrupted Stay Claims To Medicare

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

**OR**

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

# Interrupted Stay Claims And CWF

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



# **Occurrence Span Code 74 And Accommodation Revenue Codes**



# Occurrence Span Code 74 and Revenue Code 018X

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

# Example #1-B Acute Care Hospital Discharge

<b>Admission to LTCH</b>	<b>Discharge to Acute Care Hospital</b>	<b>Return No Later Than</b>
10/05/02	10/10/02	10/18/02

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

# Example #2-B IRF Discharge

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

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

# Example #3-B SNF Discharge

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

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

# Interrupted Stay Of One Day

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



# Basic UB-92 Coding For Interrupted Stays

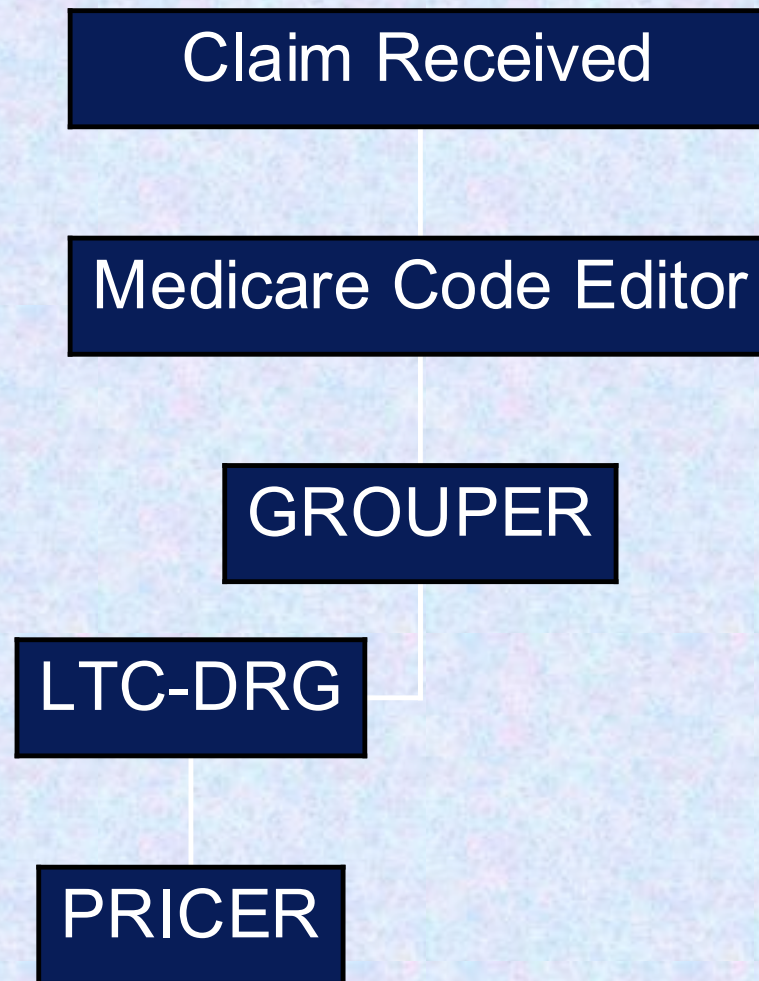
- Payable days in covered field
- Interrupted days in noncovered days field
- Applicable patient status code for discharge
- Occurrence span code 74 with dates of interruption
- Accommodation revenue code 018X
- Other coding as required
  - Ancillary revenue codes and charges

# Interrupted Stay Claim Examples

Refer to Training Guide for  
Example 1c through 3c

# Patient Classification

# LTC-DRG Processing



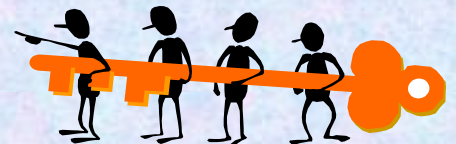
# Diagnosis And Procedure Codes

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



# Changes To Processed LTC-DRGs

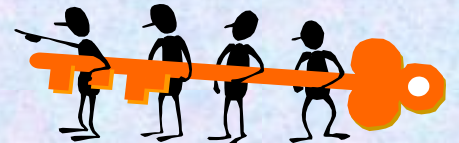
- Allowed a maximum 60 days after initial assignment to request review by FI
  - Can submit additional information
- FI recommends or denies change
  - If recommended, FI refers claim to QIO



# Furnishing Services Directly Or Under Arrangement

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

# Benefits Exhausted During Stay



# Benefits Exhaust During Stay - Utilization

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

# Benefits Exhaust During Stay – Utilization (2)

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



# Benefits Exhaust Date And Span Code 70

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

# Coding Benefits Exhaust During Stay

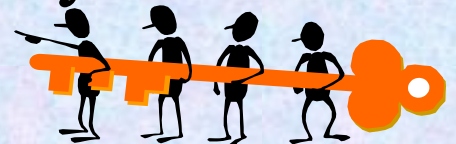
- Use type of bill 11X
- Report covered and non-covered days, as usual
- Report accommodation revenue code(s) and ancillary charges with respective covered and non-covered units and charges
- Remainder of claim coded using existing requirements

# Claim Examples - See Training Guide

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

# High Cost Outliers

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





# Coding High Cost Outliers

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



# Claim Examples - See Training Guide (2)

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

# Benefits Exhaust Prior To Stay And Other No-Pay Bills

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

# No-Payment Bills

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

# Billing - Summary

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