CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1231	**Date: APRIL 27, 2007**
	Change Request 5474

Transmittal 1231, CR 5474, originally sent via RO-4906 and CI-4668, is being recommunicated to change the Effective Date in the Business Requirements and in the manual instruction to correspond with the Effective Date on the transmittal page. Originally, the date was October 1, 2007 and the correct date is December 3, 2007. All other information remains the same.

Subject: The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Clarification of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)

I. SUMMARY OF CHANGES: Under TEFRA, the Provider Statistical and Reimbursement (PS&R) Report used the benefits exhaust date as the discharge date. This changed when the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) became effective in 2005, and the 'actual' discharge date was used to define discharge. This Change Request (CR) redefines the policy to use the benefits exhaust date as the discharge date, and is consistent with the previous methodology. This CR also clarifies that the benefits exhaust date has always been considered the discharge date for payment purposes under LTCH PPS. It also allows IPFs and LTCHs to bill no-pay bills once benefits exhaust.

New / Revised Material
Effective Date: For discharges/benefits exhaust date on or after December 3, 2007 for IPF and October 1, 2002 for LTCH
Implementation Date: December 3, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/50.2/Frequency of Billing for Providers
R	1/50.2.1/Inpatient Billing from Hospitals and SNFs
R	3/Table of Contents
R	3/40.2/Determining Covered/Noncovered Days and Charges
R	3/150.9.1.2/Interrupted Stays
R	3/150.13/Billing Requirements Under LTCH PPS

R	3/150.17/Benefits Exhausted
R	3/150.19/Interim Billing
R	3/150.23.1/Inputs/Outputs to Pricer
R	3/190.10.1/General Rules
R	3/190.10.2/Billing Period
N	3/190.12.1/Benefits Exhaust
R	3/190.17.1/Inputs/Outputs to PRICER

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

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SUBJECT: The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Clarification of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)

Effective Date: **For discharges/benefits exhaust date on or after December 3, 2007 for IPF and October 1, 2002 for LTCH.**

Implementation Date: December 3, 2007

I. GENERAL INFORMATION

A. Background: In the IPF PPS, claims are currently paid based on the date the beneficiary is physically discharged rather than on the date benefits are exhausted. In accordance with §1812 of the Act, benefits exhaust occurs when no benefit days remain in the beneficiary's applicable benefit period or when the beneficiary has exhausted the 190-day lifetime limit in a psychiatric hospital. Some psychiatric patients may have longer lengths of stays than the median length of stay of 9 days and their associated claims may cross a rate year change and would be paid at the higher rate (i.e., higher ECT rate or outlier). Currently, final bills are not submitted until the patient is officially discharged (i.e., patient physically leaves the hospital or dies), and when benefits exhaust, type of bills (TOB) 117 are submitted with a patient status code of 30 (still an inpatient), also known as continuation bills. In addition, psychiatric patients with a long length of stay may not be captured on the applicable Provider Statistical and Reimbursement (PS&R) report because they have not yet been discharged.

In the LTCH PPS, discharge is defined as (1) when the patient is formally released, (2) the patient stops receiving Medicare covered long term care services, or (3) the patient dies. Much like IPF PPS, Medicare has been paying claims on the actual discharge date, not the benefits exhaust date if present.

B. Policy: Effective for discharges/benefits exhaust date on or after December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust. The claim is paid either based on the benefits exhaust date (if present), rather than the physical discharge date. This is current policy under LTCH PPS, however it was never implemented. This CR allows the following:

- Benefits exhaust date to substitute for the discharge date (if present) for payment purposes;
- The PRICER version used will be the one in effect at the time the services were provided;
- No pay/110 TOBs are allowed once benefits have exhausted, instead of continually adjusting the claims (117 TOB) until actual physical discharge occurs (new for both IPFs and LTCHs).

Under the Tax Equity and Fiscal Responsibility Act (TEFRA), the PS&R report used the benefits exhaust date as the discharge date. This changed when both the IPF PPS and LTCH PPS were implemented, and the 'actual' discharge date was used. This CR redefines the policy and is consistent with the previous methodology. This will make it easier for contractors to use the PS&R (especially

during the blend period) to settle the cost report as the days stay with the year they occurred. This change in policy means:

1. Claims will now be settled on the appropriate cost report;
2. The appropriate PPS-TEFRA blend percentage will be paid;
3. Patients with long lengths of stay will be counted on the correct PS&R report;
4. The PRICER version used will be the one in effect at the time the services were provided (i.e., when the Medicare beneficiary had Medicare benefits).

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5474.1	The Shared System Maintainer (SSM) shall use the benefits exhaust (Occurrence Code A3, B3, or C3) date to substitute for the 'actual' discharge date on both IPF (provider number range: XX-4XXX- XX-4499, XX-SXXX, and XX-MXXX) and LTCH PPS (provider number range XX-2000 – XX-2299) claims when present.							X				
5474.2	The Shared System Maintainer (SSM) shall pass to the Medicare Code Editor, Grouper, and Pricer, the benefits exhaust date (if present) instead of the 'actual' discharge date so that the correct MCE/Grouper/Pricer software program is pulled.							X				
5474.2.1	The Shared System Maintainer (SSM) shall use the IPF or LTCH PPS Pricer version in effect at the time the services occurred (i.e., 'actual' discharge date or benefits exhaust date if present) to price claims.							X				
5474.3	The Shared System Maintainer (SSM) shall accept and process no pay claims (110 TOB) for IPF PPS and LTCH PPS, once benefits exhaust instead of requiring the adjustment of claims (117 TOB) until actual discharge occurs. (Note that 117 adjustments are still required when the beneficiary has benefits and when the patient is in a noncovered level of care.)							X				
5474.4	Contractors shall return to provider (RTP) claims that meet the benefits exhaust claim	X		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	criteria to have the provider split the claim. Providers shall add the appropriate diagnosis and/or procedure codes on the applicable claims based on the date of service (DOS).											
5474.5	The Shared System Maintainer (SSM) shall pass the benefits exhaust date (if present) instead of the 'actual' discharge date to the paid claim file.							X				
5474.5.1	The PS&R report shall use the benefits exhaust date (if present) as the discharge date for cost reporting purposes for IPF PPS and LTCH PPS.											PS&R

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5474.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5474.2	Example: A provider submits a claim with dates of service 09/25/07-10/05/07. In good faith the provider did not know that benefits would exhaust on the claim and used the appropriate diagnosis and procedure codes valid on and after 10/01/07 (the MCE effective date for this claim). The claim goes to CWF and benefits are exhausted on 09/28/07. A diagnosis code that is valid for that claim on 10/01/07 is not valid for the prior MCE, which in this case was 10/01/06. FISS will edit the claim and suspend with an MCE error. The FI's should RTP to have the provider split bill. The first claim should be a 112 with DOS 9/25/07 through 9/28/07 with a patient status 30. The next and final claim should be a 110 with dates of service 09/29/07 through 10/05/07, with the appropriate discharge patient status. Providers should resubmit the split claims with the appropriate diagnosis and procedure codes based on dates of service.
5474.1	Note: This policy has been effective for LTCH since implementation of LTCH PPS, October 1, 2002.

B. For all other recommendations and supporting information, use this space: N\A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: IPF-Dorothy Colbert at (410) 786-9671, LTCH-Judy Richter at (410) 786-2590
Claims Processing: Valeri Ritter at valeri.ritter@cms.hhs.gov or (410)786-8652

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. TITLE XVIII Contractors:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. Medicare Administrative Contractors:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

50.2 - Frequency of Billing for Providers

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Different types of providers are paid based on different payment policies depending upon the circumstance of the provider. These payment policies are described in detail in the chapters related to the provider type. The following billing requirements are to strike a balance between program administration efficiency and maintaining cash flow for providers.

Standard System Maintainer (SSM) shall ensure that providers adhere to these requirements.

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Non PPS Hospitals and SNFs

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

PPS Hospitals

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at

least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

Initial inpatient acute care PPS hospital, IRF, IPF and LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status of one of the following:

01 - Discharged to home or self care;

02 - Discharged/transferred to another short-term general hospital;

03 - Discharged/transferred to SNF;

04 - Discharged/transferred to an ICF;

05 - Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care;

06 - Discharged/transferred to home under care of an organized home health service organization;

07 - Left against medical advice;

08 - Discharged/transferred to home under care of a home IV drug therapy provider;

09 - Admitted as an inpatient to this hospital;

20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);

43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);

50 - Discharged/transferred to Hospice - home

51 - Discharged/transferred to Hospice - medical facility

61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63 - Discharged/transferred to long term care hospitals

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective April 1, 2004)

66- Discharged/transferred to a critical access hospital (CAH)

71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP).

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

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(Rev. 1231, 04-27-07)

40.2 - Determining Covered/Noncovered Days and Charges

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

The CMS must record a day or charge as either covered or noncovered because of the following:

Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care. Days denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable.

The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made, i.e., provider liable days and charges are not included. Data from the bill payment process are used in preparing the cost report.

The number of days and charges provided to the Pricer program affects the day and cost outlier determinations and the DRG payment amount. Non-PPS provider days are excluded from Pricer consideration.

It is possible to use a different number of days on a single bill for each of the above purposes, although the same number of days will generally apply in actual practice. For example, if the beneficiary had at least 1 day of eligibility remaining at admission, days that occur after benefits are exhausted up through the day outlier threshold for the applicable DRG are counted for cost reporting purposes under *I*PPS *(see section190.12.1 for IPF and section 150.17 for LTCH benefits exhaust claims processing).*

A. General Rule on Counting of Days

These following are general rules for counting days. However, these rules are also subject to special rules for determining day of admission, discharge, death, beginning a leave of absence, same day transfer, guarantee of payment days, provider liability issues and outlier days for PPS outliers. See §40.1 and §40.1.G for an explanation of these special rules.

The provider calculates and enters on the bill the number of claimable Medicare patient days on the cost report. (Medicare patient days always refer to cost report days.) For PPS facilities the FI counts, for the cost report, utilization and Pricer purposes, all days for which Part A payment may be made to the hospital. This includes days for which the provider is not liable under the limitation of liability provision. It does not count days for which no Part A payment may be made for cost report, utilization or Pricer purposes.

For non-PPS providers, the FI does not count the days for Pricer purposes, because DRG payment or outlier calculations are not made.

B. Medically Unnecessary Days for Which the Provider May Charge the Beneficiary

Days on which the hospital furnished no covered Part A services are not charged to utilization and are not counted as Medicare patient days.

If the hospital or SNF stay includes any medically unnecessary days for which the provider has met the requirements of §§40.2.2 C or D for charging the beneficiary, the FI counts those days as noncovered under Part A for cost report, utilization and Pricer purposes.

Since the provider may not be aware of the date benefits are exhausted or when the outlier threshold is reached, the FI verifies the provider's counts. If, for any reason, the FI or the QIO determines fewer days are claimable (e.g., if the FI or the QIO indicates that benefits are exhausted), the FI will adjust cost report days for its PS&R system. If the FI or the QIO determines fewer days are claimable for the cost report, it determines the proper number of days of utilization to charge the beneficiary and the proper number of days for the length of stay used by Pricer. It uses the factors in §40.1 and §40.1G to make these calculations.

C. Medically Unnecessary Outlier Costs for Which the Hospital May Not Charge

If the hospital requests payment for cost outlier, and the Medicare covered charges converted to cost exceed the cost outlier threshold, the services which are not reasonable and necessary (or constitute custodial care) which are noncovered, but for which the hospital may not charge the beneficiary are determined as follows:

- The hospital determines the lesser of the following:

    - The cost of the medically unnecessary services (converting the charges for the medically unnecessary services to cost); or

    - The amount by which the adjusted cost of the stay exceeds the cost outlier threshold.

Ancillary services, which are not required to be furnished on an inpatient basis, are treated as medically unnecessary, but nevertheless may be covered under Part B.

- If the costs in excess of the outlier threshold exceed the cost of the medically unnecessary services, the cost of all of the medically unnecessary services are treated as noncovered costs. If these costs exceed the costs in excess of the cost outlier threshold, beginning with the cost of the last medically unnecessary service in the stay, the hospital must identify, and add on, in reverse order, the cost of other medically unnecessary services until the total cost of medically unnecessary services reaches the costs in excess of the cost outlier threshold. If the cost of the last service to be added on in this manner brings the cost of

medically unnecessary services over the amount of costs in excess of the cost outlier threshold, only the portion of the cost of that last medically unnecessary service (in the order of the addition) needed to bring the total of the medically unnecessary costs up to the costs in excess of the cost outlier threshold is added on. In this case, the costs in excess of the cost outlier threshold are treated as the noncovered costs.

- Once the costs of medically unnecessary services to be treated as noncovered are determined, convert them to charges for each applicable service/revenue category, e.g., accommodations, radiology, pharmacy, by dividing the costs treated as not medically necessary in each category by 72 percent. The medically unnecessary charges determined are treated as noncovered charges. Days for which all costs are found to be noncovered are treated as noncovered days.

- The hospital determines which medically unnecessary services and days treated as noncovered are services and days for which the beneficiary can be charged under §40.2.2C or E. The remainder of the services and days are the medically unnecessary services and days treated as noncovered even though the hospital may not charge the beneficiary. However, the distinction between medically unnecessary services and days for which the hospital may charge, and those for which it may not, will not be reflected in the charges shown on the inpatient hospital billing. Both are combined and shown as noncovered services and days.

The determination of medically unnecessary cost outliers is not affected by non-entitlement days or days after benefits are exhausted. If the stay is covered or treated as covered, the beneficiary is treated as entitled to Part A, and as having benefits available throughout the stay.

150.9.1.2 - Interrupted Stays

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

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 *an* LTCH during which *the* 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 *and RY 2006*, 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. Effective for dates of service on or after July 1, 2006 *(RY 2007),* this limited exception for surgical DRGs is no longer applicable. No further separate payment to an acute care hospital will be made. Any tests or procedures, that were administered to the patient during that period of time of interruption 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 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.)

150.13 - Billing Requirements Under LTCH PPS

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to incorporate the following so that FIs accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X.

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 software will determine DRG

assignment.

Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill *(note that the day in which benefits exhaust is considered a "discharge" for payment purposes*).

Effective December 3, 2007, once a patient's Medicare benefit's exhaust, the LTCH is allowed to submit no-pay bills until physical discharge or death.

150.17 - Benefits Exhausted

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

The day benefits exhaust is considered a "discharge" for payment purposes under LTCH PPS.

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

150.19 - Interim Billing

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Interim bills are allowed every 60 days. *Refer to Chapter 1, section 50.2 for specifics on interim billing under PPS.*

Effective December 3, 2007, LTCHs are allowed to submit no-pay bills (TOB 110) once benefit's exhaust, every 60 days. They do not have to continually adjust bills until physical discharge or death once benefit's exhaust. The last bill shall contain a discharge patient status code.

150.23.1 - Inputs/Outputs to Pricer

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Inputs

- Provider Specific File Data; Fields-1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 18, 19, 21, 22, and 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). Effective July 1, 2005, FIs shall no longer populate fields 12, 13, or 14. Field 35 must be populated for all LTCHs. Fields 33 and 38 shall be populated if applicable. Effective July 1, 2006, data elements 23, 24, 27, 28, and 49 are required. See the section "Determining the Cost-to-Charge Ratio" 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 *(or benefit's exhaust date if present (Occurrence Code A3, B3, or C3))*
    - Length of Stay (LOS)
    - Covered Days
    - Lifetime Reserve Days (LTR)
    - DRG (from Grouper)

Outputs

- PPS Return Code
- MSA/CBSA (CBSAs will be returned for discharges on or after July 1, 2005).
- 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

190.10.1 - General Rules

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must code diagnoses correctly; using ICD-9-CM codes for the principal diagnosis, and up to eight additional diagnoses, if applicable;
- The IPF must code procedures correctly using ICD-9-CM Volume III codes for one principal procedure and up to five additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and
- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date *(or effective December 3, 2007, benefits exhaust date, if present)* on the claim will determine the DRG assignment.

190.10.2 - Billing Period

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

When the patient has Medicare benefits, IPF providers will submit one admit through discharge claim for the stay upon discharge. IPFs may interim bill in 60-day intervals following the instructions in chapter 1, §50.2 of this manual should the patient's stay be exceptionally long. Final PPS payment is based upon the *date of physical discharge or death, or the date benefits exhausted (effective December 3, 2007).*

IPFs can submit adjustment claims, but late charge claims will not be allowed, e.g., the adjustment claim must include all charges and services and must replace the earlier claim(s) instead of including only the additional charges and services.

In situations when a patient falls below a skilled level of care, IPFs should submit a 112 TOB with both an Occurrence Code 22 (Date active care ended) and patient status code 30 (Still a patient). IPFs should then continue to submit subsequent interim 117 TOBs, as appropriate, with the patient status code 30 and the correct Occurrence Span Codes that identify payment liability (codes 76 or 77).

Effective December 3, 2007, once the patient's Medicare benefit's exhaust, the IPF is allowed to submit no-pay bills (TOB 110), with a Patient Status Code of 30 every 60 days, until the patient is physically discharged or dies. The last bill shall contain a discharge patient status code. IPFs no longer need to continually adjust claims once benefits exhaust.

190.12.1- Benefits Exhaust

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Effective December 3, 2007, for payment purposes, an IPF discharge occurs when benefits exhaust and the date benefits exhaust (if present) will substitute for the 'actual' discharge date. The claim is paid based on the benefits exhaust date if present rather than the discharge date. The Pricer version used to price claims for the discharge is when the services actually were provided (i.e., when the Medicare beneficiary has Medicare benefits). No pay/110 TOBs are allowed instead of continually adjusting the claims (117 TOB) until actual discharge occurs once benefits exhaust.

Under TEFRA, the PS&R report used the benefits exhaust date as the discharge date (if present). This changed when the IPF PPS was implemented, and the 'actual' discharge date was used. The days stay with the year they occurred, making it easier for the PS&R report (especially during the blend period) to settle the cost report. This means that:

1. *Claims will now be settled on the appropriate cost report;*
2. *The appropriate PPS-TEFRA blend percentage will be paid;*
3. *Patients with long lengths of stay will be counted on the correct PS&R report;*
4. *The PRICER version used will be the one in effect at the time the services were provided (i.e., when the Medicare beneficiary actually has Medicare benefits).*

190.17.1 - Inputs/Outputs to PRICER

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator
9	Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.
12	Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)
17	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
18	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)
23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)
38	Special Wage Index
48	New Hospital

Bill Data

National Provider Identifier	Covered Charges
OSCAR Number	Discharge Date *(or benefits exhaust date if present)*
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment
DRG Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
Per Diem Adjusted Payment
Facility Adjusted Payment
Age Adjusted Payment
Rural Adjusted Payment
Teaching Adjusted Payment
ED Adjusted Payment
ECT Adjusted Payment
Return Code
MSA/CBSA
Wage Index
National Labor Rate

National Non-Labor Rate
Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate
Standardized Factor
Labor Share
Non-Labor Share
COLA
Day of Stay Adjustment
Age Adjustment
Comorbidity Adjustment
DRG Adjustment
Rural Adjustment
ECT Adjustment
Blend Year Calculation Version