CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1544	**Date: September 22, 2015**
	Change Request 9015

Transmittal 1513, dated June 24, 2015, is being rescinded and replaced by Transmittal 1544 to:

- **remove the sensitive and controversial status,**
- **remove the 'NOTE' in business requirements 9015.7 and 9015.8,**
- **revise the 'NOTE' in business requirement 9015.11,**
- **replace references of psychiatric/rehabilitative diagnosis to specified psychiatric/rehabilitation DRG,**
- **replace references of ventilation DRG to specified ventilation procedure code**
- **update business requirements 9015.15 and 9015.16 to remove patient status codes '63' and '91' and add applicable second position return codes.**

All other information remains the same.

SUBJECT: Implementation of Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Based on Specific Clinical Criteria

I. SUMMARY OF CHANGES: Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients.

EFFECTIVE DATE: Discharges in cost reporting periods beginning on or after October 1, 2015.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015; October 5, 2015

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not

obliged to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Medicare currently pays for inpatient hospital services for long-term care hospital discharges under the LTCH PPS. Under this payment system, CMS largely sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital receives a single payment for the case based on the payment classification, i.e., the MS-LTC-DRGs assigned at discharge. LTCHs are required to meet the same Medicare conditions of participation (COPs) as acute care hospitals that are paid under the Inpatient Prospective Payment System (IPPS). Under existing law, the primary criteria for a hospital to be designated as an LTCH for Medicare payment purposes is a "greater than 25 day average length of stay" requirement. Until the recent enactment of the 2013 Bipartisan Budget Act, however, there were no clinical criteria concerning the patients treated in LTCHs. Specifically, section 1206 of this Act establishes two distinct payment categories under the LTCH PPS: "standard" payments for patient discharges meeting specific clinical criteria and "adjusted" payments for those discharges that do not meet the specified clinical criteria. These payment categories are described below.

B. Policy: Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients: upon discharge, LTCH cases meeting specific clinical criteria will be paid a standard LTCH PPS payment (i.e., what is presently being paid under existing LTCH PPS policy); and those cases not meeting specific clinical criteria will be paid based on a "site neutral" basis, i.e., the lesser of an "IPPS-comparable" payment amount or 100 percent of the estimated cost of the case. In order to be paid at the standard LTCH PPS amount, an LTCH patient must either:

1) have been admitted directly from an IPPS hospital during which at least 3 days were spent in an intensive care unit (ICU) or coronary care unit (CCU) but the discharge must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis; or

2) have been admitted directly from an IPPS hospital and the LTCH discharge is assigned to an MS-LTC-DRG based on the receipt of ventilator services of at least 96 hours but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy and the Interrupted Stay policy, will continue to apply in determining the standard LTCH PPS payment for those discharges meeting specific clinical criteria.

The “site neutral” amount will be paid for patients discharged from the LTCH that do not meet one or both of the above criteria.

Site Neutral payments shall not change the beneficiary’s out of pocket costs. Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the Medicare payment. Days after benefits are exhausted are not charged against the beneficiary's utilization whether or not the hospital receives the full MS-LTC-DRG payment.

If there is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium) if a site neutral payment is made, the remaining "inlier" days of the stay will be considered covered until the high cost outlier is reached even though the beneficiary is not using any Medicare covered days. The beneficiary shall not be responsible for non-utilization days. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the life-time reserve days.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9015.1	Medicare contractor shall load the new LTCH PPS PRICER. A BETA version will be available with the July release. The final version occurs with the October Recurring update notification.					X				
9015.2	LTCH PPS PRICER shall maintain the current calculation for LTCH reimbursement which will be named Standard LTCH Payment.									LTCH Pricer
9015.3	Medicare contractor shall process claims based on the new LTCH PPS for LTCHs whose cost reporting periods begin on or after October 1, 2015.	X				X				
9015.4	Medicare contractor shall update the valid values for blend years in the PSF to include 6, 7 or 8.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9015.4.1	Medicare contractor shall update the Federal PPS Blend Indicator (data element 18, file position75) in the Provider Specific File (PSF) for LTCH PPS with the appropriate value as follows: 6 – Blend Year 1 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015) 7 - Blend Year 2 (represents 50% site neutral payment and 50 % standard payment effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2015) 8 – Transition Blend no longer applies	X								
9015.5	Medicare contractor shall assign one of the following review codes for the LTCH PRICER formatted as PIC 9(02) to tell PRICER how to pay the claim: 00, 01, 02, 03, 04, 05, 06, 07, 08					X				
9015.5.1	Medicare contractor shall assign review codes based on the following: 00 - LTCH through date is within the effective dates of the PRICER (10/01/15 – 09/30/16), but the through date occurs prior to the provider's cost report period start date. Example: Through date is 11/05/15, but the provider's cost report start date is January 1, 2016. 01-LTCH through date is during the provider's cost reporting period beginning on or after 10/01/15 (Price either as site neutral or standard depending on whether criteria are met) or CWF Reject 3 is received. (Price as LTCH Standard PPS) 02-Assign when CWF Reject 1 is received. (Price as Site Neutral)					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	03- Assign when CWF Reject 2 is received. (Price as Site Neutral) 04- Assign when CWF IUR 1 is received. (Price as Standard) 05-Assign when CWF IUR 2 is received. (Price as Standard) 06-Assign when CWF IUR 3 is received. (Price as Site Neutral) 07-Assign when CWF IUR 4 is received. (Price as Site Neutral) 08-Assign when CWF IUR 5 is received. (Price as Site Neutral)									
9015.5.2	Medicare contractor shall pass review codes listed above in BR 5.1 as part of the input record to the LTCH PPS PRICER.					X				
9015.6	LTCH PRICER shall accept the review codes from the Medicare contractor.									LTCH Pricer
9015.6.1	LTCH PRICER shall price the claim based on the following review code instructions: 00-Price claim under previous LTCH PPS (Original) 01-Price claim using new LTCH PPS policy for claims with a through date during cost reporting periods beginning on or after 10/01/15. 02-Price claim as site neutral 03- Price claim as site neutral 04- Price claim as standard 05- Price claim as standard									LTCH Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	06- Price claim as site neutral 07- Price claim as site neutral 08- Price claim as site neutral									
9015.6.2	LTCH PPS PRICER shall price site neutral claims the lesser of an "IPPS-comparable" payment amount (as applied under the SSO policy at CFR 412.529) or 100 percent of the estimated cost of the case.									LTCH Pricer
9015.7	Medicare contractor shall pass 25 procedure code fields to input record of LTCH PRICER.					X				
9015.7.1	LTCH PPS PRICER shall expand input record to accept 25 procedure codes.									LTCH Pricer
9015.8	Medicare contractor shall pass 25 diagnosis code fields to input record of LTCH PRICER.					X				
9015.8.1	LTCH PPS PRICER shall expand input record to accept 25 diagnosis codes.									LTCH Pricer
9015.8.2	LTCH PPS PRICER shall create a table to house specified psychiatric and rehabilitation related DRGs.									LTCH Pricer
9015.9	LTCH PPS PRICER shall default the payment method to standard at initial processing except for claims with specified psychiatric and rehabilitation related DRGs.									LTCH Pricer
9015.10	Medicare contractors shall redefine the return code field as alphanumeric to accommodate new return codes.					X				FPS, IDR, LTCH Pricer, NCH, PS&R
9015.10.1	LTCH PPS PRICER shall create new return codes as listed in Attachment A titled List of New PRICER Return Codes.									LTCH Pricer
9015.10.1.1	LTCH PPS PRICER shall use return codes DH - DL for errors as necessary.									LTCH Pricer
9015.10.2	Medicare contractor shall accept new PRICER					X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	return codes from the LTCH PPS PRICER.									
9015.11	LTCH PPS PRICER shall output the following payment amount fields formatted as 9(07)V99: Site Neutral payment amount based on Cost Site Neutral payment amount based on IPPS Full Standard payment amount SSO Standard payment amount NOTE: For claims affected by the new policy in this CR the amounts contained in the four new fields are included in the total payment amount returned by PRICER. The dollar amounts in each field do not contain outlier payments. For non - blended payments only one of the four fields will be populated. For blended payments two of the four fields will be populated representing a 50% site neutral payment and 50% standard payment.									LTCH Pricer
9015.11.1	The Contractor shall accept new fields that house the new LTCH PPS Payment Amounts.					X	X		X	LTCH Pricer
9015.11.2	These fields shall be passed to CWF.					X	X		X	
9015.11.3	Contractor shall ensure the new fields are passed to the downstream systems.					X	X		X	FPS, IDR, MedPar, NCH, PS&R
9015.12	Medicare contractors shall continue to read the third through sixth position of the provider number to identify LTCH provider (XX2000 – XX2299).					X			X	
9015.13	Medicare contractors shall identify IPPS hospitals (XX0001 – XX0999) and Maryland Waiver								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	hospitals (210001 – 210999) as satisfying the requirement that the patient was admitted directly from an IPPS hospital. NOTE: Non-subsection (d) hospitals including but not limited to Cancer hospitals (050146, 050660, 100079,100271, 220162, 330154, 330354, 360242, 390196, 450076 and 500138) and Critical Access Hospitals (XX1300-XX1399) cannot fulfill the IPPS admission qualification.									
9015.14	Medicare contractor shall not read history to verify an IPPS claim is present when the first position of the Return Code is an 'A' indicating Site Neutral payment due to presence of a specified psychiatric or rehabilitation DRG on the incoming LTCH claim.								X	
9015.15	Medicare contractor shall read history to verify the presence of a qualifying IPPS claim when the first position of the Return Code is 'B' identifying the presence of a specified ventilator procedure code and the second position of the Return Code is 'D', 'E', 'F' or 'G' identifying a standard payment. A qualifying IPPS claim must have: • a discharge date equal to the incoming LTCH claim admission date or • a discharge date one day prior to the incoming LTCH claim admission date The IPPS claim may also qualify if no payment is made and the following no pay codes are present: • 'B' • 'R' • blank (ex. Primary payer paid in full)								X	
9015.15.1	Medicare contractor shall reject the LTCH claim if a qualifying IPPS history claim described above is								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	not found.									
9015.15.2	Medicare contractor shall allow the reject code to be overridden.								X	
9015.15.3	Medicare contractor shall accept new CWF reject 1 and assign review code 02.					X				
9015.16	Medicare contractor shall read history to verify the presence of a qualifying IPPS claim with 3 or more units of ICU or CCU present when the first position of the Return Code is 'C' identifying an LTCH claim that does not have a specified psychiatric or rehabilitation DRG or an LTCH claim that does not have a specified ventilator procedure code and the second position of the Return Code is 'D', 'E', 'F' or 'G' identifying a standard payment. The qualifying IPPS claim must have: • a discharge date equal to the incoming LTCH claim admission date with 3 or more units present with revenue code 020X or 021X or • a discharge date one day prior to the incoming LTCH claim admission date The IPPS claim may also qualify if no payment is made and the following no pay codes are present: • 'B' • 'R' • blank (ex. Primary payer paid in full)								X	
9015.16.1	Medicare contractor shall reject the LTCH claim if an IPPS history claim described above does not have 3 or more units of revenue code 020X or 021X.								X	
9015.16.2	Medicare contractor shall allow the reject code to be overridden.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9015.16.3	Medicare contractor shall accept new CWF reject 2 and assign review code 03.					X				
9015.17	Medicare contractor shall reject the LTCH claim with a specified ventilator procedure code when a qualifying IPPS claim is present but the PRICER return code is B0 – B7, BA, BB or BC identifying a site neutral payment.								X	
9015.17.1	Medicare contractor shall allow the reject code to be overridden.								X	
9015.17.2	Medicare contractor shall accept new CWF reject 3 and assign review code 01.					X				
9015.18	Medicare contractor shall reject the LTCH claim that does not have a specified psychiatric or rehabilitation DRG code or a specified ventilator procedure code when a qualifying IPPS claim is present but the PRICER return code is C0 – C7, CA, CB or CC identifying a site neutral payment. NOTE: This can be the same reject as above in BR17								X	
9015.19	Medicare contractor shall identify when an incoming IPPS claim meets the criteria to change the payment of the LTCH claim in history.								X	
9015.20	Medicare contractor shall create 5 new IURs (informational unsolicited responses) with all the required data to identify the LTCH claim that needs to be adjusted to correct the method of payment as follows: 1. LTCH history claim has specified ventilator procedure code and PRICER return code B0-B7, BA, BB or BC and incoming IPPS claim meets qualifying criteria. 2. LTCH history claim does not have a specified psychiatric or rehabilitation DRG,								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	does not have a specified ventilator procedure code and has PRICER return code C0-C7, CA, CB or CC and incoming IPPS claim meets qualifying criteria. 3. LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is a cancel. 4. LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is an adjustment to change the discharge date so that it is no longer a qualifying claim. 5. LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is an adjustment to reduce the number of ICU/CCU units so that it is no longer a qualifying claim.									
9015.20.1	Medicare contractor shall accept new CWF IURs.					X				
9015.20.2	Upon receipt of the IUR, Medicare systems shall perform an automated adjustment to the paid 11x LTCH claim to correct the payment method as follows: • IUR 1- LTCH history claim has a specified ventilator procedure code and incoming IPPS claim meets qualifying criteria. Medicare contractor shall assign review code 04 to the LTCH claim to change payment from site neutral to standard. • IUR 2 - LTCH history claim does not have a specified psychiatric or rehabilitation DRG and does not have a specified ventilator procedure code and incoming IPPS claim meets qualifying criteria. Medicare contractor shall assign review code 05 to					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	LTCH claim to change payment from site neutral to standard. • IUR 3 - LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is a cancel. Medicare contractor shall assign review code 06 to change payment from standard to site neutral • IUR 4 - LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is an adjustment to change the discharge date so that it is no longer a qualifying claim. Medicare contractor shall assign review code 07 to change payment from standard to site neutral • IUR 5 - LTCH history claim has PRICER return code BD, BE, BF, BG, CD, CE, CF, or CG and the incoming IPPS qualifying claim is an adjustment to reduce the number of ICU/CCU units so that it is no longer a qualifying claim. Medicare contractor shall assign review code 08 to change payment from standard to site neutral.									
9015.20.3	Medicare contractors shall continue to assign the group code currently being assigned to LTCH paid claims on the electronic remittance advice (ERA) and the standard paper remittance (SPR) advice.	X								
9015.20.4	Medicare contractors shall continue to assign appropriate Claims Adjustment Reason Codes (CARC) currently assigned to LTCH claims on the ERA and SPR.	X								
9015.20.5	Medicare contractors shall assign new Remittance Advice Remark Code (RARC) N741 – This is a site neutral payment, on LTCH claims with PRICER return code A0 – A7, AA, AB, AC, B0-B7, BA, BB, BC, C0 – C7, CA, CB or CC on the ERA and	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	SPR.									
9015.21	Medicare contractors shall continue to apply utilization as is currently applied on an LTCH claim for standard paid claims. Any non-utilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be identified using OSC 70.					X			X	
9015.22	For site neutral paid claims, Medicare contractors shall follow the same benefit application rules as IPPS claims, including application of LTR days for benefits exhausted in the inlier period.					X			X	
9015.23	Medicare contractors shall attend up to 6 calls with CMS during the SDLC for July and October in order to provide a status and address any issues that might arise from installation, coding and testing of the new PRICER.					X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9015.24	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's 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				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5, 13-20	Attachment C - Claim processing flow charts
3	Attachment B - Examples of Blend Years for Different Cost Reporting Periods.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo at Cami.DiGiacom@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

ATTACHMENTS: 3

LTCH PPS based on Clinical Criteria PRICER RETURN CODES

A0	Blend year Site Neutral Payment based on cost. Psychiatric/Rehabilitation DX present.
A1	Blend year Site Neutral Payment based on cost, with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Psychiatric/Rehabilitation DX present.
A2	Blend year Site Neutral Payment based on cost -SSO. Psychiatric/Rehabilitation DX present.
A3	Blend year Site Neutral Payment based on cost, SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Psychiatric/Rehabilitation DX present.
A4	Blend year Site Neutral Payment based on IPPS. Psychiatric/Rehabilitation DX present.
A5	Blend year Site Neutral Payment based on IPPS , with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Psychiatric/Rehabilitation DX present.
A6	Blend year Site Neutral Payment based on IPPS, SSO. Psychiatric/Rehabilitation DX present.
A7	Blend year Site Neutral Payment based on IPPS, SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Psychiatric/Rehabilitation DX present.
AA	Site Neutral Payment based on cost. Psychiatric/Rehabilitation DX present.
AB	Site Neutral Payment based on IPPS. Psychiatric/Rehabilitation DX present.
AC	Site Neutral Payment based on IPPS with Outlier. Psychiatric/Rehabilitation DX present.
B0	Blend year Site Neutral Payment based on cost. Vent DRG present.
B1	Blend year Site Neutral Payment based on cost, with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Vent DRG present.
B2	Blend year Site Neutral Payment based on cost -SSO . Vent DRG present.
B3	Blend year Site Neutral Payment based on cost -SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Vent DRG present.
B4	Blend year Site Neutral Payment based on IPPS . Vent DRG present.
B5	Blend year Site Neutral Payment based on IPPS , with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Vent DRG present.
B6	Blend year Site Neutral Payment based on IPPS -SSO. Vent DRG present.
B7	Blend year Site Neutral Payment based on IPPS, SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). Vent DRG present.
BA	Site Neutral Payment based on cost. Vent DRG present.
BB	Site Neutral Payment based on IPPS. Vent DRG present.
BC	Site Neutral Payment based on IPPS with Outlier. Vent DRG present.
BD	SSO Standard Payment. Vent DRG present.
BE	SSO Standard Payment with Outlier. Vent DRG present.
BF	Standard Payment full DRG. Vent DRG present.
BG	Standard Payment full DRG with Outlier. Vent DRG present.
C0	Blend year Site Neutral Payment based on cost. No psych/rehab dx and no vent DRG
C1	Blend year Site Neutral Payment based on cost, with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). No psych/rehab dx and no vent DRG
C2	Blend year Site Neutral Payment based on cost -SSO. No psych/rehab dx and no vent DRG
C3	Blend year Site Neutral Payment based on cost, SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). No psych/rehab dx and no vent DRG
C4	Blend year Site Neutral Payment based on IPPS. No psych/rehab dx and no vent DRG
C5	Blend year Site Neutral Payment based on IPPS , with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). No psych/rehab dx and no vent DRG
C6	Blend year Site Neutral Payment based on IPPS, SSO. No psych/rehab dx and no vent DRG
C7	Blend year Site Neutral Payment based on IPPS, SSO with Outlier (from 50% of site neutral calculation and/or 50% of standard calculation). No psych/rehab dx and no vent DRG
CA	Site Neutral Payment based on cost. No psych/rehab dx and no vent DRG
CB	Site Neutral Payment based on IPPS. No psych/rehab dx and no vent DRG
CC	Site Neutral Payment based on IPPS with Outlier. No psych/rehab dx and no vent DRG
CD	SSO Standard Payment. No psych/rehab dx and no vent DRG
CE	SSO Standard Payment with Outlier. No psych/rehab dx and no vent DRG
CF	Standard Payment full DRG. No psych/rehab dx and no vent DRG
CG	Standard Payment full DRG with Outlier. No psych/rehab dx and no vent DRG
DH	Reserved for future use
DI	Reserved for future use
DJ	Reserved for future use

DK	Reserved for future use
DL	Reserved for future use

Blend Years and Cost Report Periods

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from January to December, and was a Medicare provider no later than 10/01/15.

PRICER Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16	10/01/15 – 12/31/15	Current policy
	01/01/16 – 09/30/16	Blend Year 1
10/01/16 – 09/30/17	10/01/16 – 12/31/16	Blend Year 1
	01/01/17 – 09/30/17	Blend Year 2
10/01/17 – 09/30/18	10/01/17 – 12/31/17	Blend Year 2
	01/01/18 – 09/30/18	Full Cost vs. IPPS

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from January to December and was a Medicare provider effective 01/01/16.

PRICER Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
	01/01/16 – 09/30/16	Blend Year 1
10/01/16 – 09/30/17	10/01/16 – 12/31/16	Blend Year 1
	01/01/17 – 09/30/17	Blend Year 2
10/01/17 – 09/30/18	10/01/17 – 12/31/17	Blend Year 2
	01/01/18 – 09/30/18	Full Cost vs. IPPS

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from January to December and was a Medicare provider effective 01/01/17.

PRICER Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
10/01/16 – 09/30/17	01/01/17 – 09/30/17	Blend Year 2
10/01/17 – 09/30/18	10/01/17 – 12/31/17	Blend Year 2
	01/01/18 – 09/30/18	Full Cost vs. IPPS

Attachment B Blend Year Cost Report

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from January to December and was a Medicare provider effective 01/01/18.

PRICER Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
10/01/16 – 09/30/17		
10/01/17 – 09/30/18		
	01/01/18 – 09/30/18	Full Cost vs. IPPS

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from October to September, and was a Medicare provider effective 10/01/16.

PRICER Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
10/01/16 – 09/30/17	10/01/16 – 09/30/17	Blend Year 2
10/01/17 – 09/30/18	10/01/17 – 09/30/18	Full Cost vs. IPPS

The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from October to September and was a Medicare provider effective 10/01/17.

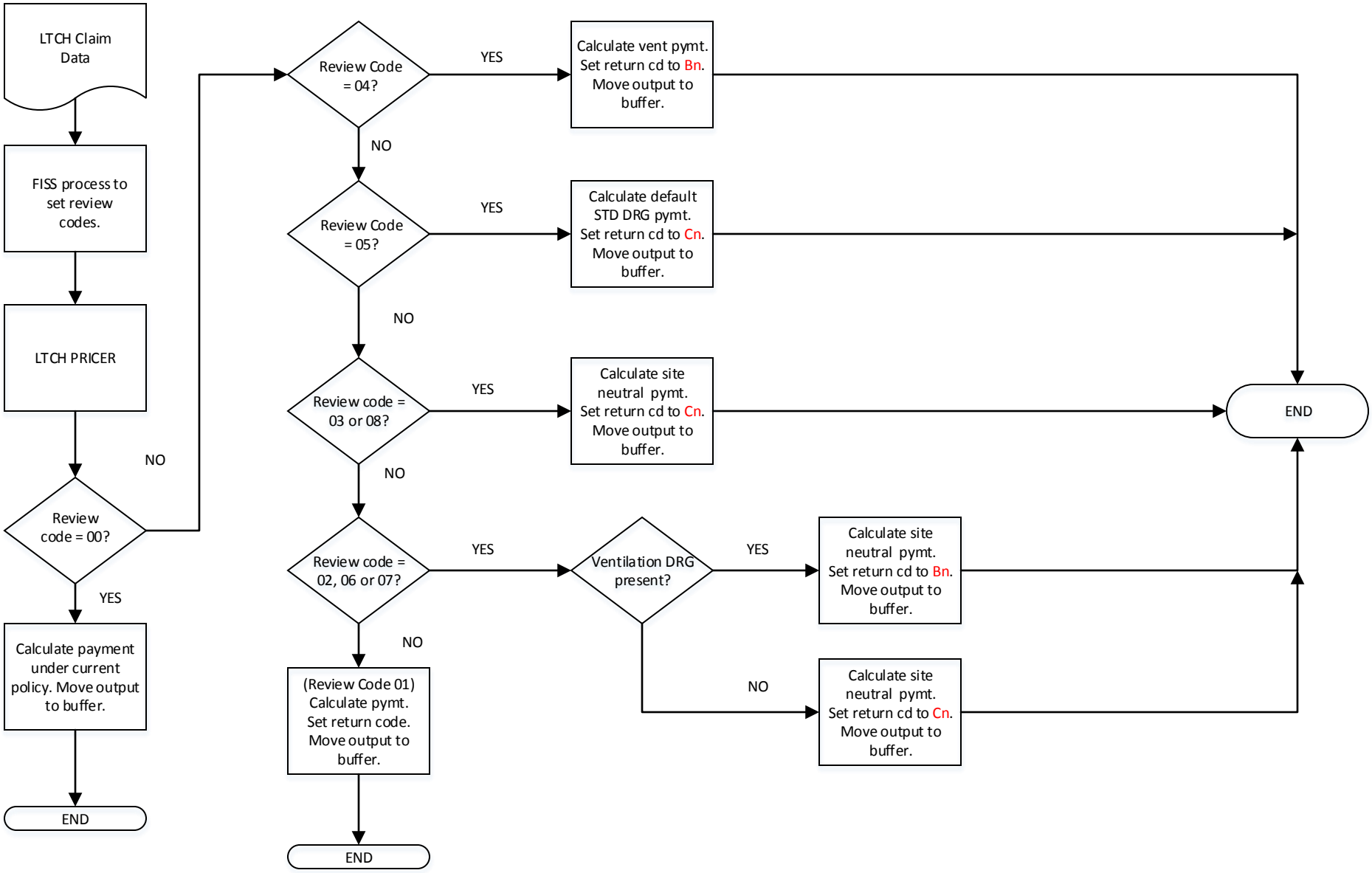
Pricer Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
10/01/16 – 09/30/17		
10/01/17 – 09/30/18	10/01/17 – 09/30/18	Full Cost vs. IPPS

Attachment B Blend Year Cost Report

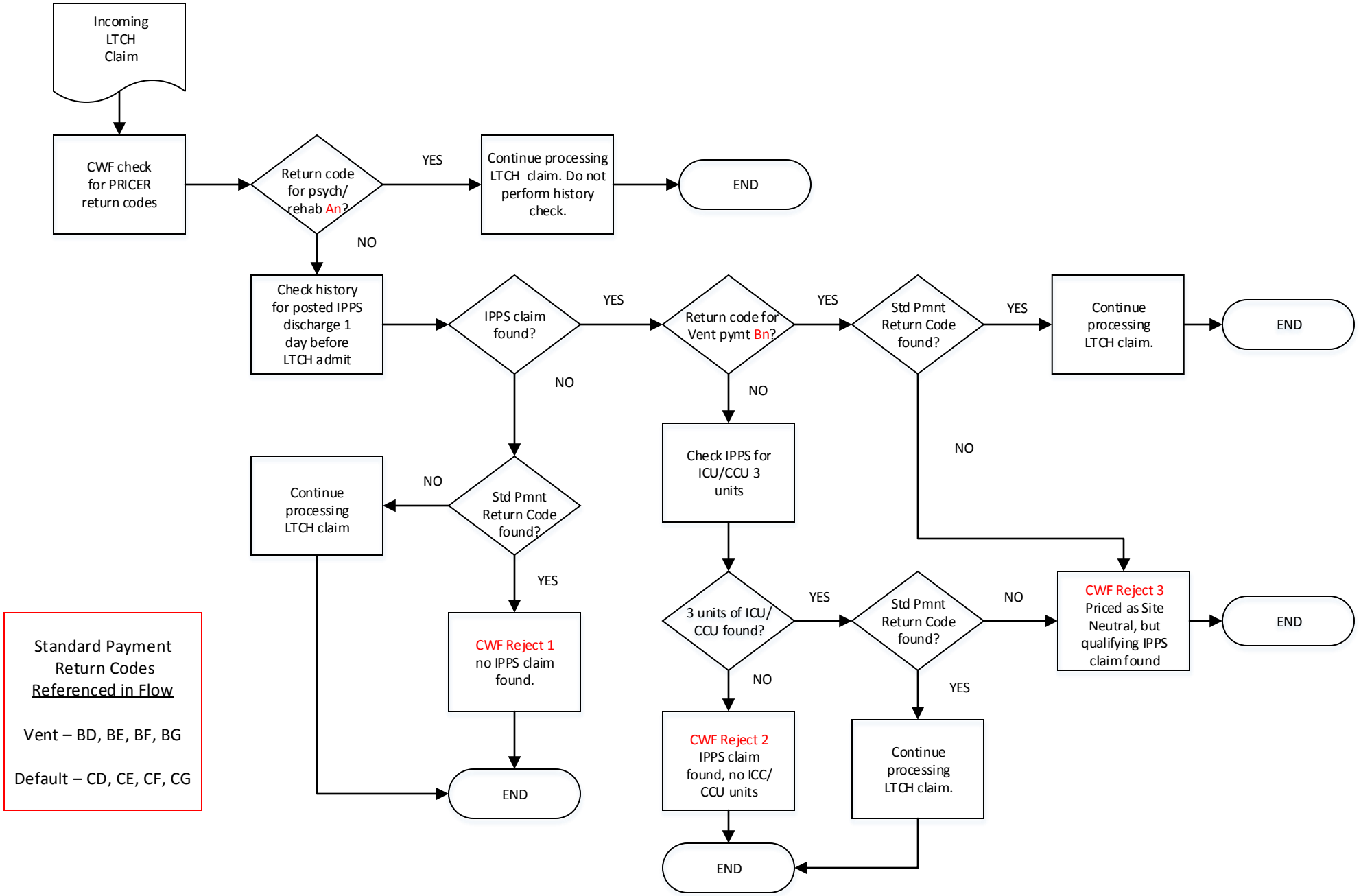
The chart below shows how an LTCH claim will pay assuming the provider's cost reporting period runs from September to August and was a Medicare provider effective 09/01/17.

Pricer Period	Claim Discharge Period	Payment
10/01/15 – 09/30/16		
10/01/16 – 09/30/17		
	09/01/17 – 09/30/17	Blend Year 2
10/01/17 – 09/30/18	10/01/17 – 08/31/18	Blend Year 2
	09/01/18 – 09/30/18	Full Cost vs. IPPS

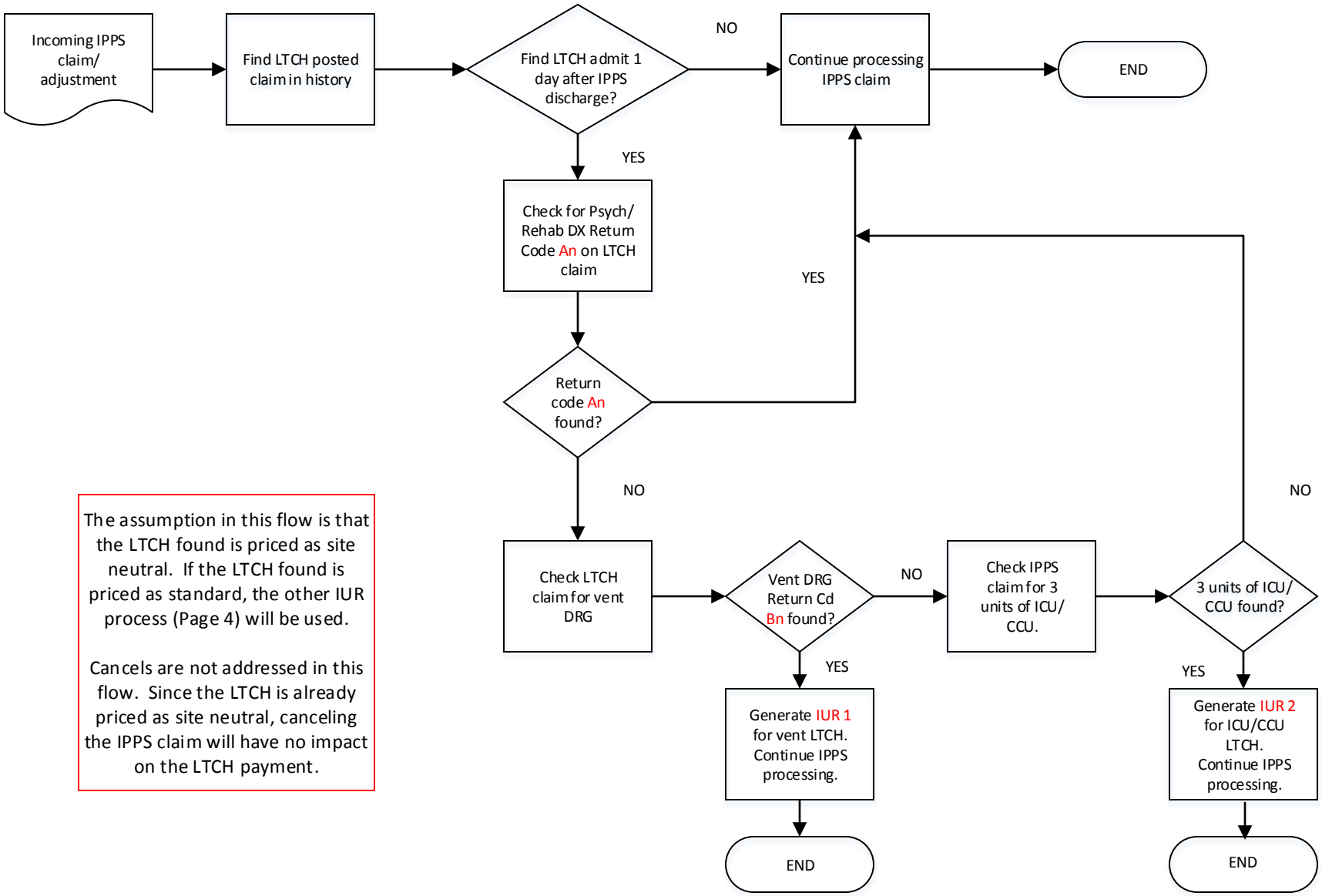
LTCH Claim Through PRICER



CWF Processing Incoming LTCH Claim



CWF IUR Processing: Site Neutral to Standard Payment



The assumption in this flow is that the LTCH found is priced as site neutral. If the LTCH found is priced as standard, the other IUR process (Page 4) will be used.

Cancels are not addressed in this flow. Since the LTCH is already priced as site neutral, canceling the IPPS claim will have no impact on the LTCH payment.

CWF IUR Processing: Standard Payment to Site Neutral