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Billing Compliant Long-Term Care Hospital Inpatient Claims

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Part A

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Objective

- Assist LTCHs in understanding Medicare's guidelines for submitting IP claims for services rendered to Medicare beneficiaries by providing an overview of such guidelines

Agenda

- General LTCH information
- Billing resources, claim form, FLs and billing codes
- Frequency of billing and TOBs
- BE during LTCH stay
- Miscellaneous IP situations
- Wrap Up
- Resources
- Questions and answers

General LTCH Information

LTCHs

- Must meet same Medicare certification requirements as short-term ACHs
- Generally treat medically complex patients who require long-stay hospital level of care
- Must average an IP LOS of > 25 days for Medicare payment classification purposes
- Paid under LTCH PPS since 10/1/2002
  - Federal payment rate (MS-LTC-DRG)

LTCH PPS and MS-LTC-DRGs

- LTCH PPS uses MS-LTC-DRGs as a patient classification system
  - Same MS-DRGs under IPPS but weighted to reflect resources LTCH patients use
- Each patient stay is grouped into MS-LTC-DRG based on
  - Diagnoses, procedures (up to 25), age, gender and discharge status
- Each MS-LTC-DRG has predetermined ALOS
  - CMS updates ALOS annually based on latest available LTCH discharge data
- We pay
  - For each patient based on MS-LTC-DRG group if discharge is excluded from site neutral payment rate
  - Cases assigned to MS-LTC-DRG based on Federal payment rate, including any payment and policy adjustments

Did You Know…

- To understand payment under LTCH PPS as well as billing and benefit day application, LTCHs must be familiar with the term SSO threshold. An SSO threshold is equal to 5/6ths of an LTC-DRG's ALOS.

MS-LTC-DRG Payment

- We make MS-LTC-DRG payment when
  - Beneficiary has enough Medicare IP hospital benefit days to exceed SSO threshold, and
  - Beneficiary's LOS exceeds SSO threshold
- MS-LTC-DRG payment example:
  - If ALOS for specific MS-LTC-DRG = 12 days
    - SSO threshold (5/6ths of ALOS) = ten days
  - MS-LTC-DRG payment made if
    - Beneficiary has more than 11 IP hospital benefit days, and
    - Beneficiary's LOS is at least 11 days

LTCH PPS Payment – Site Neutral vs. Standard

- For CRPs on or after 10/1/2015, we pay discharges
  - Site neutral payment rate when specific clinical criteria are not met
    - Generally lower of:
      - IPPS equivalent to per diem amount (under SSO policy, including any HCO payment)
      - Estimated costs of case (allowable charges X LTCH's CCR)
  - Federal payment rate when specific clinical criteria are met (subject to SSO and interrupted stay policies):
    - Beneficiary is admitted directly to LTCH from IPPS hospital where at least three nights were spent in ICU or CCU or
    - Beneficiary is admitted directly to LTCH from IPPS hospital and LTCH discharge is assigned to MS-LTC-DRG based on receipt of ventilator services of at least 96 hours
      - » LTCH discharge must not have psychiatric or rehabilitation principal diagnosis or DRG

Check Your Payments

- If you receive site neutral payment but believe standard payment criteria was met (e.g.; preceding stay occurred but claim not submitted to Medicare)
  - Refer to MLN Matters® *SE1627: Further Information on the Implementation of LTCH PPS Based on Specific Clinical Criteria*
  - Gather documentation to support standard payment criteria met
  - Contact PCC to request claim adjustment to pay standard
    - Do not appeal
  - Fax documentation to PCC

Impact of COVID-19 PHE on Payment

- Certain site neutral payment rate provisions are waived:
  - Payment adjustment for LTCHs that do not have a DPP for period that is at least 50%
    - For calculating DPP, all admissions during PHE are counted in numerator of calculation, that is, LTCH cases admitted during PHE are counted as discharges paid standard Federal payment rate
  - Application of site neutral payment rate for admissions in response to PHE and occurring during PHE
    - All LTCH cases admitted during PHE are paid standard Federal rate
    - New PRICER was released in April 2020 to include temporary payment policy for claims with admission dates on/after 1/27/2020 and through duration of PHE
- Refer to COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

SSO Payment Policy and Payment Adjustment

- SSO payment policy
  - Helps prevent inappropriate payment for cases without full episode of care
- SSO payment adjustment
  - Applicable to standard Federal payment rate discharges (not site neutral)
  - May occur when beneficiary discharges to another facility or to home, dies, or exhausts benefits during stay
  - Applies when LOS is from one day to 5/6ths of ALOS for MS-LTC-DRG case is grouped to and MS-LTC-DRG payment is subject to SSO adjustment
- For SSO discharges on/after 10/1/2017
  - We pay blend of amount comparable to what Medicare would pay under IPPS, calculated as per diem and capped at full IPPS equivalent amount and MS-LTC-DRG per diem amount

SSO Payment

- SSO payment is made when
  - Beneficiary does not have enough IP hospital benefit days to exceed SSO threshold, and/or
  - Beneficiary's LOS does not exceed SSO threshold
- SSO payment example:
  - If ALOS for specific MS-LTC-DRG = 12 days
    - SSO threshold (5/6ths of ALOS) = ten days
  - SSO payment made if
    - Beneficiary has ten or less IP hospital benefit days, and/or
    - Beneficiary's LOS is ten days or less

HCO Payment

- Additional payment for unusually high costs
  - Beneficiary must have a IP hospital benefit day for each medically necessary day in HCO period
    - HCO period begins day after accumulated covered charges reach HCO threshold
    - HCO threshold = MS-LTC-DRG + fixed loss amount

Medicare Benefit Days

- Up to 150 IP hospital benefit days under Part A
  - 90 regular days (renewable per benefit period)
    - 60 full days and 30 coinsurance days
  - 60 LTR coinsurance days (not renewable)
    - Special policy for use of LTR days; only applies in LTCH
- Benefit period
  - Period of time for measuring utilization of benefits
    - Refer to CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 10.4

LTR Days – Policy for Use

- If beneficiary does not have enough regular IP hospital benefit days to exceed SSO threshold, he/she can use LTR days to exceed it
  - So MS-LTC-DRG can be paid
- Once LTR days are started, beneficiary must continue to use them for each remaining day of stay until discharged
  - Even if no additional payment is generated

LTR Days – Policy for Use Example

- ALOS for specific MS-LTC-DRG = 12 days
- SSO threshold (5/6ths of ALOS) = ten days
- Beneficiary's LOS is at least 11 days
- Beneficiary has ten regular IP hospital benefit days and five LTR days
- We apply
  - All ten regular IP hospital benefit days
  - At least one LTR day (if LOS = 11 days)
  - Additional LTR days (up to four more) if LOS continues

Billing Resources, Claim Form, FLs and Billing Codes

Billing Resources

- Complete IP LTCH claims per CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1
    - Section 50.2.1, Frequency of Billing
  - Chapter 3
    - Section 150.13 Billing Requirements Under LTCH PPS
    - Section 150.17 Benefits Exhausted
    - Section 150.19 Interim Billing
  - Additional resources noted on slides

Claim Form, Claim FLs and Claim Billing Codes

- Claim form
  - UB-04 form; also known as CMS-1450 form
- Claim FLs
  - Billing code fields
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
- Claim billing codes
  - Options to enter in billing code fields
    - Refer to NUBC's UB-04 Data Specifications Manual available on NUBC website

Claim FLs

- Claim FLs and descriptions
  - FL 4 = TOB
  - FL 6 = Statement covers period (from and through dates)
  - FL 12 = 12 = Date of admission
  - FL 14 = Priority (type) of admission
  - FL 15 = Point of origin for admission
  - FL 17 = PSC
  - FLs 18-28 = CCs
  - FLs 31-34 = OCs and dates

Claim FLs

- Claim FLs and descriptions
  - FLs 35-36 = OSCs with from/through dates
  - FLs 39-41 = VCs and amounts
  - FL 42 = Revenue code
  - FL 44 = HCPCS/Rates/HIPPS Rate codes (accommodation rate)
  - FL 46 = Unit(s) of service
  - FL 47 = Total charges (not needed for electronic billing)
  - FL 48 = Noncovered charges

Claim FLs

- Claim FLs and descriptions
  - FL 67 = Principal diagnosis code
  - FLs 67 A-Q = Other diagnosis codes
  - FL 69 = Admitting diagnosis code
  - FL 74 = Principal procedure code and date
  - FLs 74 A-E = Other procedure codes and dates
  - FL 80 = Remarks

Frequency of Billing and TOBs

Frequency of Billing Guidelines for LTCHs

- Submit
  - Admission to discharge claim or
  - Interim claims every 60 days while beneficiary has IP hospital benefit days available
- If benefits exhaust during LTCH stay, submit
  - Interim claim(s) through benefits exhaust date and
  - Subsequent no-payment claims in 60-day increments until beneficiary's final discharge or death

TOBs for Inpatient LTCH Claims

- "One claim per stay" concept
  - TOBs
    - **110** = No-payment claim; use is limited
    - **111** = Admission to discharge claim
    - **112** = First interim claim
    - **117** = Adjustment including interim claims
    - **118** = Cancel claim
    - **12X** = IP ancillary claim

TOB 110

- No-payment claim
  - Submitted even when no payment expected from Medicare
- Submit
  - For all noncovered IP stays
    - Except when beneficiary enrolled in Medicare Part B only
  - At beneficiary's final discharge or in 60-day increments

TOB 110 Situations

- Submit TOB 110 when
  - Beneficiary's IP hospital benefit days exhausted
    - At admission
    - During LTCH stay
      - Must submit interim claim(s) through benefits exhaust date first
  - Beneficiary at noncovered LOC for entire stay
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.2 letter E

Did You Know…

- If you admit a beneficiary at a noncovered LOC and submit TOB 110 (no-payment) claims, you must cancel these claims, and submit corrected claims, if the beneficiary's care becomes covered during the stay.
  - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.1

TOB 111

- An IP claim from admission to final discharge
  - Statement from date must = admission date
    - Unless payment window policy applies
- Submit
  - At beneficiary's final discharge
- Do not submit
  - If beneficiary's IP hospital benefit days exhaust during stay

TOBs 112 and 117 as Interim Claims

- Interim claims
  - TOB 112 = First 60-day interim claim
  - TOB 117 = Subsequent 60-day interim claims
    - Each contains original stay(s) plus each subsequent 60 day periods
- May submit
  - If beneficiary's stay greater than 60 days
- Must submit
  - If beneficiary's IP hospital benefit days exhaust during stay

Interim Claims – Less Than 60 Days

- Interim claims, TOBs 112 and 117, can include less than 60 days if
  - Beneficiary's IP hospital benefit days exhaust
  - Beneficiary discharged/ transferred from LTCH
  - Beneficiary dies before 60 more days have passed

Interim Claims – Claim Coding

- Interim claim must have:
  - **TOB** = 112/117
  - **Admission date** = original date of admission
  - **Statement from date** = date of admission unless payment window applies
  - **Statement through date** = 60th day date, benefits exhaust date (OC A3 and date), discharge date/date of death (if final claim)
  - **PSC** = 30 (still a patient) or appropriate PSC (if final claim)
  - **Claim change reason code** = D3 on all TOBs 117
  - **Diagnosis and procedure codes/dates** = as applicable from admission date to claim's through date

TOB 117

- Adjustment claim
  - Changes or corrects original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires claim change reason code
    - D0 (zero) through E0 (zero) – **see next slide**
    - Describes reason for adjustment
    - **Note:** Adjustments to final claims resulting in a higher paying LTC-DRG must be submitted within 60 days of original claim's processed date (CC = D4)

Claim Change Reason Codes

- Codes and descriptions:
  - **D0** = Change to service dates
  - **D1** = Change to charges
  - **D2** = Change in revenue codes/HCPCS/HIPPS rate code
  - **D3** = Second or subsequent interim PPS bill
  - **D4** = Change in clinical codes (ICD) for diagnosis and/or procedure codes/Grouper PRICER input (DRG) IP hospital
  - **D7** = Change to make Medicare secondary
  - **D8** = Change to make Medicare primary
  - **D9** = Any other change
  - **E0** = Change in patient status

TOB 118

- Cancel claim
  - Cancels original claim
  - Requires claim change reason code
    - D5 or D6
      - **D5** = Cancel-only to correct a HIC number or provider identification number
      - **D6** = Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of OP bill with services required to be on IP bill)

TOB 12X

- IP ancillary claim for services to inpatients (furnished directly or under arrangement) submitted under Part B when Part A cannot make payment
  - Report revenue codes, HCPCs codes, units, LIDOS and charges
  - Billable services depend on reason IP stay cannot be paid
    - If IP stay not medically R&N per MAC or MRC
      - Refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1
    - If beneficiary doesn't have Part A or exhausted IP hospital benefit days
      - Refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2

Did You Know…

- There are several services which, when provided to a hospital inpatient, are covered under Part B, even though the beneficiary has Part A coverage for the hospital stay.
  - Refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 250

TOB 12X for Vaccines and Administration

- You may submit TOB 12X for vaccines and administration provided to inpatients
  - Influenza, PPV, and hepatitis B
  - Use discharge date of hospital stay or date IP hospital benefit days exhausted
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2.1

Benefits Exhaust During LTCH Stay

LTCH Must Submit a Claim Through BE Date When BE During Stay

- If BE during LTCH stay, you must submit
  - Interim claim(s) (TOBs 112 and 117) through BE date
    - Even if 60 additional days not passed
  - Subsequent no-payment claims (TOBs 110) in 60-day increments until beneficiary's final discharge or death
    - Once BE claim (TOB 112 or 117) finalized by Medicare
- Do not use TOB 111 when submitting claims through BE date; always use interim claim TOB

Determining BE Date – Two Options

- BE date
  - Last date on which IP hospital benefit day available
  - OC = A3 with date
- You can determine BE date
  - Using Medicare benefit day availability information in CWF
    - HIQA, if available (no longer updated)
    - HIPAA Eligibility Transaction System (HETS)
    - Our IVR system
    - NGSConnex
- You can let Medicare determine BE date upon receipt of claim (preferred method)

Submitting Claims When BE During Stay – Using BE Date You Determined

- Submit one claim through BE date you determined
  - **TOB** = 112 if no prior interim claim submitted or 117 if prior interim claim submitted
  - **Admission date** = Date of original admission
  - **Statement from date** = Date of original admission unless payment window applies
  - **Statement through date** = BE date
  - **PSC** = 30
  - **OC** = A3 with BE date

BE Date Affected by LTCH PPS

- Under LTCH PPS, BE date depends on whether or not beneficiary has enough IP hospital benefit days
  - To exceed SSO threshold
    - Whether or not he/she
      - Has enough regular (full and/or coinsurance) IP hospital benefit days to exceed it
      - Needed LTR days to exceed it
  - To cover each medically necessary day in any HCO period
    - When claim qualifies for HCO

Medicare Makes Corrections to BE Dates Reported by LTCH

- When you submit claim through BE date you determined, we ultimately RTP claim to have you
  - Report date on which HCO threshold exceeded (OC 47 and date) in certain cases – see next slide
  - Correct BE date you reported (OC A3 date)
  - Correct statement through date you reported (claim must end, be cut/split, at appropriate BE date)

HCO Period and OC 47 Date

- Some claims qualify for HCO
  - LTCH
    - Submits claim for processing
    - May receive RTP claim with HCO threshold amount
    - Adds daily covered charges until accumulated covered charges reach HCO threshold amount
    - Reports OC 47 and date = day after HCO threshold reached
  - We (Medicare)
    - Determine if beneficiary has enough or right combination of benefit days for each medically necessary day in HCO period
    - RTP claim again if necessary

Submitting Claims When BE During Stay – Let Medicare Determine BE Date

- You can submit claims without BE date (OC A3)
  - This will lessen number of times we must RTP claims due to incorrect BE date and/or HCO
  - We will determine appropriate BE date for your claim based on LTCH PPS claim processing and benefit day application guidelines
  - Be aware that BE date we determine may not necessarily be same as date of beneficiary's last IP hospital benefit day was available

Submitting Claims When BE During Stay – Let Medicare Determine BE Date

- Submit claim through at least next 60-day interim billing period
  - **TOB** = 112 if no prior interim claim or 117 if prior interim claim submitted
  - **Admission date** = Date of original admission
  - **Statement from date** = Date of original admission unless payment window applies
  - **Statement through date** = First or subsequent 60-day period
  - **PSC** = 30
  - Report all medically necessary days as covered
    - Up to 150 days regardless of how many days available in CWF
    - For days above 150, report as noncovered but associated charges as covered

Submitting Claims When BE During Stay – Medicare Determines BE Date

- Upon receipt of claim, we
  - Apply LTCH PPS processing guidelines
  - Determine appropriate BE date
  - RTP claim with
    - Reason code 7A000
    - OC A3 and appropriate BE date
    - Remarks asking you to correct your statement through date (to end/cut/split) claim as of this date

No-Payment Claims Following BE Claim

- Wait for BE claim to finalize
- First no-payment claim after BE
  - **TOB** = 110
  - **Admission date** = Original date of admission
  - **Statement from date** = Day after through date submitted on prior TOB 110
  - **Statement through date** = 60th day or date of discharge or death if final claim
  - **PSC** = 30 or appropriate PSC if final claim
  - **All days/services** = noncovered

No-Payment Claims Following BE Claim

- Subsequent no-payment claims after BE
  - **TOB** = 110
  - **Admission date** = Original date of admission
  - **Statement from date** = Day after through date submitted on prior TOB 110
  - **Statement through date** = 60th day or date of discharge or death if final claim
  - **PSC** = 30 or appropriate PSC if final claim
  - **All days and services** = noncovered

Miscellaneous Inpatient Situations

Furnish or Arrange Services for Inpatients

- All items and nonphysician services furnished to inpatients must be furnished directly by hospital or billed through hospital under arrangements
  - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 10.4 (Exceptions noted)
  - If LTCH arranges for inpatient to receive OP services at another facility (and he/she returns by midnight)
    - Pay other facility
    - Submit IP claim and report revenue code of service provided by other facility and applicable costs, including transportation costs if any
      - Do not report transportation revenue code 0540

Noncovered Care

- Include claim coding for any periods of time during which beneficiary is at noncovered LOC
  - OC 31 and date provider notified beneficiary
  - VC 31 and amount of charges provider may bill beneficiary for hospitalization that was not medically R&N
  - OSC 76 with from/through dates
    - Beneficiary liability
    - You are permitted to charge beneficiary
    - You notified beneficiary in writing prior to “from” date of this period

Noncovered Care

- OSC 77 with from/through dates
  - Provider liability (other than for lack of medical necessity or custodial care)
  - Beneficiary's record charged with utilization
  - You may collect deductible and/or coinsurance
- OSC M1 with from/through dates
  - Provider liability (care denied due to lack of medical necessity or as custodial care)
  - Beneficiary's record not charged with utilization
  - You may not collect deductible and/or coinsurance

One-Day LTCH Stay In Between Two ACH Stays

- Beneficiary transferred from ACH, admitted to LTCH, then readmitted to same ACH by midnight of same day
  - Example:
    - Transferred to LTCH from ACH 12/20/2020, 8:00 a.m.
    - Admitted to LTCH 12/20/20120 at 10:00 a.m.
    - Readmitted to same ACH 12/20/2020 at 10:30 p.m.
- ACH determines if two ACH stays are related
  - Their decision affects who LTCH will bill
    - Refer to:
      - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.5
      - CR3389: Revision of CWF Editing for Same-Day, Same- Provider Acute Care Readmissions

One-Day LTCH Stay In Between Two ACH Stays

- If ACH determines its two stays **are related**
  - It submits one claim (combining both ACH stays) and pays intervening facility (LTCH) under arrangements
    - LTCH bills ACH; not Medicare
- If ACH determines its two stays **are not related**
  - It submits two claims (one for each stay) and intervening facility submits its own claim
    - LTCH bills Medicare as a same day transfer claim – see next slide

Same-Day Transfer

- Beneficiary admitted to LTCH but transferred to another facility as an inpatient on same day before midnight
- Submit one-day IP claim and report
  - Same admission date, from date and through date
  - One noncovered day
  - Covered units/charges
  - CC 40

Beneficiary Admitted to LTCH Prior to Medicare Entitlement Date

- Beneficiary admitted prior to their Medicare Part A entitlement date
  - Submit claim to Medicare for services from Part A entitlement date
    - Report
      - From date = Part A entitlement date and
      - Admission date = IP admission date (date on which beneficiary formally admitted to LTCH as inpatient)

One-Day Payment Window Policy

- Applies when payment can be made on Part A claim
  - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3 , Section 40.3 and Chapter 4, Section 10.12
- Admitting LTCH reports on its IP claim
  - All OP diagnostic services it rendered
    - On day of and/or on day prior to IP LTCH admission
  - All nondiagnostic services it rendered
    - On day of IP LTCH admission
    - On day prior to IP LTCH admission unless LTCH deems such services not related to IP LTCH stay

One-Day Payment Window Policy – Reporting Outpatient Services on Inpatient Claim

- When you report applicable OP services on IP claim, include:
  - Revenue code(s) and charges
  - ICD-10 procedure(s) and associated date(s)
  - Diagnosis code(s)
  - Actual IP admission date
  - Statement from date = earliest OP DOS added
    - MLN Matters® *SE1117: Correct Provider Billing of Admission Date and Statement Covers Period*

One-Day Payment Window Policy – Admitting LTCH

- Admitting LTCH includes
  - Any entity LTCH wholly-owns or wholly-operates or any entity under arrangement with LTCH
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Sections 90.7 and 90.7.1

One-Day Payment Window Policy – OP Service Types

- OP diagnostic services defined by revenue code
  - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3 , Section 40.3
- OP nondiagnostic services defined by revenue code
  - No CMS listing but revenue codes (and HCPCS codes) not on CMS's diagnostic revenue code/HCPCS code list considered nondiagnostic
- LTCHs submit OP nondiagnostic services separately if
  - Rendered on day prior to date of LTCH admission and
  - LTCH attests such services are not related to LTCH stay by adding CC 51 to claim

One-Day Payment Window Policy – Unrelated Outpatient Nondiagnostic Services

- CC 51 on OP claim
  - Attests such services are clinically distinct or independent from reason for beneficiary's IP admission (unrelated to IP admission)
  - You must have documentation to support this decision
  - Claim may be subject to subsequent review
  - Claim subject to Medicare's timely filing guidelines

Patient Is MAO Plan Enrollee for Only a Portion of Billing Period

- Plan effective at time of admission is responsible for entire IP stay
  - FFS Medicare is responsible
    - If beneficiary enrolled in FFS Medicare at time of admission
  - MAO plan is responsible
    - If patient enrolled in MAO plan at time of admission
      - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 90

Teaching LTCH Billing FFS Medicare for MAO Plan Enrollee

- After billing MAO plan, submit IP claim to FFS Medicare and report:
  - Covered TOB 11X (not TOB 110)
  - Covered days/charges
  - CCs 04 and 69
  - FFS Medicare as first payer (obtain MBI from beneficiary)
    - Do not submit as MSP claim
  - All other required claim elements
- Medicare processes claim:
  - Rejects with reason code 37574 resulting in TOB 110
  - Pays for medical education (DGME and/or N&AH, as applicable) via cost report
    - CR2476: Payment to Hospitals and Units Excluded from the Acute IPPS for DGME and N&AH Education for M+C Enrollees

Nonteaching LTCH Billing FFS Medicare for MAO Plan Enrollee

- After billing MAO plan, submit IP claim to FFS Medicare and report:
  - Covered TOB 11X (not TOB 110)
  - Covered days/charges
  - CC 04
  - FFS Medicare as first payer (obtain MBI from beneficiary)
    - Do not submit as MSP claim
  - All other required claim elements
- Medicare processes claim:
  - With reason code 3719C; as TOB 111
  - For DSH calculation
    - CR5647 Revised: Capturing Days on Which Medicare Beneficiaries are Entitled to Medicare Advantage (MA) in the Medicare/Supplemental Security Income (SSI) Fraction
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 20.3

What You Should Do Now…

- Review resources slides
- Share information with other staff members
- Follow instructions for submitting LTCH claims
- Develop and implement policies that ensure claims are correctly submitted to Medicare
- Attend future education for LTCHs

Resources

National Government Services Website

- Visit our website for information on
  - PCC phone numbers (under Contact Us)
  - IVR
  - NGSConnex
  - Education:
    - Webinars, Teleconferences & Events Calendar
    - Medicare University
    - New Provider Center
    - POE Advisory Group

CMS Resources

- Fact Sheet: FY 2021 Medicare Hospital IPPS and LTCH Final Rule (CMS-1735-F)
- LTCH Fact Sheet
- LTCH Pricer
- LTCH Web page
- MLN Matters® *SE1117: Correct Provider Billing of Admission Date and Statement Covers Period*
- MLN Matters® *SE1627: Further Information on the Implementation of LTCH PPS Based on Specific Clinical Criteria*

CMS Resources – IOMs

- Internet-Only Manuals (IOMs)
  - CMS IOM Publications
    - **100-01, *Medicare General Information, Eligibility and Entitlement Manual***
      - **Chapter 3,** Section:
        - 10.4, Benefit Period (Spell of Illness)
    - **100-02, *Medicare Benefit Policy Manual***
      - **Chapter 6**, Sections
        - 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
        - 10.2, Other Circumstances in Which Payment Cannot Be Made Under Part A
      - **Chapter 15**, Section
        - 250, Medical and Other Health Services Furnished to Inpatients of Hospitals and SNFs

CMS Resources – IOMs

- **100-04, *Medicare Claims Processing Manual***
  - **Chapter 1**, Sections
    - 50.2.1, Inpatient Billing From Hospitals and SNFs
    - 90, Patient Is Member of a MA Organization for Only Portion of Billing Period
  - **Chapter 3**, Sections
    - 10.4, Payment of Nonphysician Services for Inpatients
    - 20.3, Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients
    - 40.2.2, Charges to Beneficiaries for Part A Services
    - 40.2.5, Repeat Admissions
    - 40.3, Outpatient Services Treated as Inpatient Services
    - 150.13, Billing Requirements Under LTCH PPS
    - 150.17, Benefits Exhausted
    - 150.19, Interim Billing

CMS Resources – IOMs

- **100-04, *Medicare Claims Processing Manual***
  - **Chapter 4**, Section
    - » 10.12, Payment Window for Outpatient Services Treated as Inpatient Services
  - **Chapter 12**, Sections
    - » 90.7, Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window
    - » 90.7.1, Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)
  - **Chapter 18**, Section
    - » 10.2.2.1, Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration on Institutional Claims
  - **Chapter 25**, Section
    - » 75, General Instructions for Completion of Form CMS-1450 for Billing

CMS Resources – CRs

- CR2476: Payment to Hospitals and Units Excluded from Acute IPPS for DGME and N&AH Education for M+C Enrollees
- CR3389: Revision of CWF Editing for Same-Day, Same-Provider Acute Care Readmissions
- CR5474 Revised: Use of BE Day as Day of Discharge for Payment Purposes for IPF PPS and Clarification of Discharge for LTCHs and Allowance of No-Pay BE Bills (TOB 110)
- CR5647 Revised: Capturing Days on Which Medicare Beneficiaries are Entitled to MA in Medicare/SSI Fraction

CMS Resources – CRs

- CR9015 Revised: Implementation of LTCH PPS Based on Specific Clinical Criteria
- CR11361: FY 2020 IPPS and LTCH PPS Changes
- CR11616: Implementation of LTCH DPP Adjustment
- CR11679: SSI/Medicare Beneficiary Data for FY 2018 for IPPS Hospitals, IRFs, and LTCHs
- CR11742: Quarterly Update to LTCH PPS FY 2020 Pricer
- CR11879: FY 2021 IPPS and LTCH PPS Changes

Deficit Care Programs
Diabetes Awareness

- Let's Raise Awareness!
- Three types of Diabetes Medicare benefits for your Medicare beneficiaries
  - Medicare Diabetes and Prevention Program (MDPP)
  - Diabetes Self-Management Training (DSMT)
  - Medical Nutrition Therapy (MNT)
- Encourage your patients to participate in these programs

Behavioral Health Integration Services Psychiatric Collaborative Care Model

- Integrating behavioral health care (BHI) with primary care is an effective strategy for improving outcomes for the millions of Americans with mental or behavioral health conditions
- Medicare makes separate payments to physicians and nonphysician practitioners for BHI services they furnish to beneficiaries over a calendar month
- **What is the Psychiatric Collaborative Care Model?**
  - Model of behavioral health integration that enhances "usual" primary care by adding two key services to the primary care team
    1. **Care management support for patients receiving behavioral health treatment**
    2. **Regular psychiatric inter-specialty consultation**

Deficit Care Program Resources

- NGSMedicare.com > Medical Policy & Review> Policy Education Topics
- **Diabetes Awareness**
  - Medicare Diabetes Prevention Program
  - Diabetic Self-Management Tool for Billing
  - Medical Nutrition Therapy Tool for Billing
  - Frequently Asked Questions for Diabetes Self-Management Training and Medical Nutrition Therapy
  - Related Diabetes Awareness Preventive Service Guide
- **Mental Health Awareness**
  - Behavioral Health Integration Services
  - Mental Health Services
  - Mental Health Billing Guide

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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