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Long-Term Care Hospitals: Preparing and Submitting Compliant Inpatient Claims

07/24/2025

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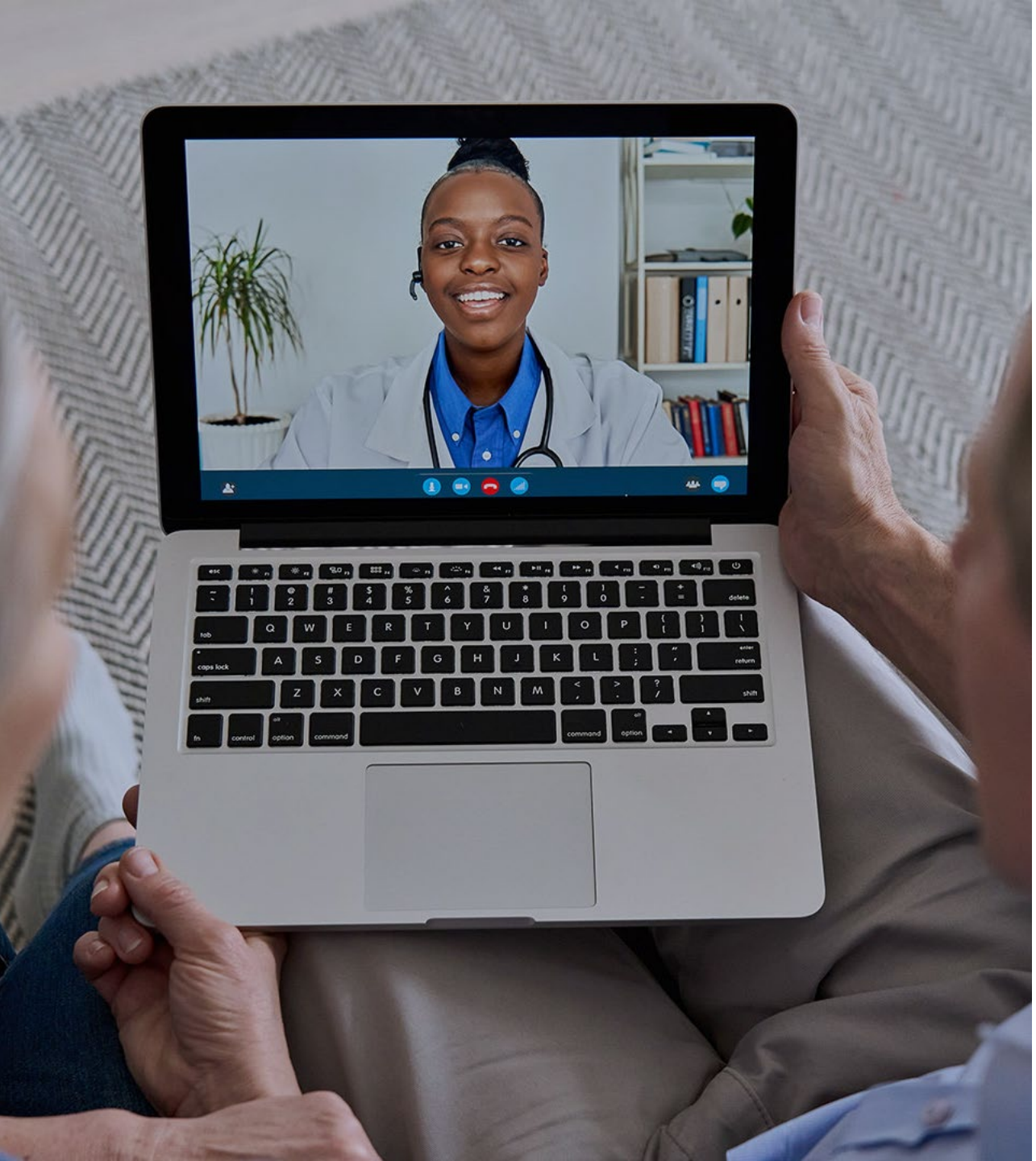

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Objective

Assist LTCHs in understanding how to prepare and submit compliant claims to Medicare so fewer of your claims RTP or reject for billing errors

Today's Presenters

- Provider Outreach and Education Consultants
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

Agenda (continued)

Billing and Claim Resources

Billing Resources

- Complete LTCH claims in accordance with CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 50.2.1
  - Chapter 3, Section 150

Claim Resources

- Claim form
  - UB-04/CMS-1450
  - 837I claim
  - Claim entry in FISS DDE
- Claim fields
  - UB-04/CMS-1450 claim FLs (1-81)
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
- Claim codes
  - NUBC members access in NUBC's UB-04 Data Specifications Manual

FLs for Provider, Patient and Insurance Information

- Provider identification
  - FLs 1, 5, 56 and 76-79
- Patient identification
  - FLs 3A, 3B and 8-11
- Insurance identification (if Medicare primary)
  - FLs 50A-55A and 58A-60A
- Insurance identification (if Medicare secondary)
  - FLs 50B-55B and 58B-60B
    - MSP claims: Prepare and Submit a Medicare Secondary Payer Claim

FLs for IP Claims

- 4 = TOB
- 6 = Statement covers period (from and through dates)
- 12 = Date of admission
- 14 = Priority (type) of admission
- 15 = Point of origin for admission
- 17 = PSC as of statement covers period through date (FL 6)
- 18-28 = CCs
- 31-34 = OCs and dates
- 35-36 = OSCs with from/through dates
- 39-41 = VCs and amounts
- 42 = Revenue codes

FLs for IP Claims (continued)

- 44 = HCPCS/Rates/HIPPS Rate codes (accommodation rate)
- 46 = Unit(s) of service
- 47 = Total charges (not for electronic billing)
- 48 = Noncovered charges
- 64 = DCN
- 67 = Principal diagnosis code
- 67 A-Q = Other diagnosis codes
- 69 = Admitting diagnosis code
- 74 = Principal procedure code and date
- 74 A-E = Other procedure codes and dates
- 80 = Remarks

Before Submitting Claims to Medicare

- Check claim for completeness and accuracy
  - Are all services reported on claim?
  - Are all required data elements entered?
- Check if claim already submitted
  - To prevent duplicate claim submissions
- Follow one-year timely filing requirement
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

Submitting Claims to Medicare – Options

- Hardcopy UB-04/CMS-1450 claim form
  - Claim's Department addresses
  - Must have approved ASCA waiver
    - ASCA Requirements for Paper Claim Submission
- 837I claim
  - EDI and How it Works
  - MLN® Booklet *Medicare Billing: CMS-1450 & 837I*
- FISS DDE claim entry
  - *FISS DDE Provider Online Guide – Claim Data Entry*
- Vendor/clearinghouse

After Submitting Claims to Medicare

- Check FISS DDE to determine claim S/LOC and provider action
  - P B9997 – Claim processed
    - Verify payment accuracy under LTCH PPS (site neutral vs. standard)
  - S XXXXX – Claim suspended
    - Wait for claim to process, RTP, reject or deny
  - T B9997 – Claim RTP
    - Make necessary claim corrections and select PF9 to resubmit claim
  - R B9997 – Claim rejected
    - Determine if action needed; may have to resubmit (or adjust) claim
  - D B9997 – Claim denied
    - Determine if appeal needed; documentation must support services rendered

LTCH PPS Payment – Site Neutral vs. Standard

- We pay discharges at
  - Site neutral payment rate when specific clinical criteria not met
  - Standard federal payment rate when specific clinical criteria met
    - Beneficiary admitted directly to LTCH from IPPS hospital and
      - At least three nights were spent in IPPS hospital ICU or CCU or
      - LTCH's discharge assigned to LTC-DRG based on receipt of ventilator services of at least 96 hours
      - Note: In either case, LTCH discharge can't have psychiatric or rehabilitation principal diagnosis or LTC-DRG

Requesting Standard Payment When Site Neutral Payment Received

- If you receive site neutral payment but believe claim met standard payment criteria
  - Follow: Long-Term Care Hospitals: How to Request Adjustments of Claims Paid at the Site Neutral Rate
    - Must provide PCC reasoning and any requested documentation
      - E.g., IPPS hospital stay occurred, but that hospital did not submit claim to Medicare
  - Do not submit appeal request to Appeals Department

Frequency of Billing and TOBs

Frequency of Billing for LTCHs

- Submit IP claims through final discharge or death
  - While beneficiary has IP hospital benefit days available, submit
    - Admission to discharge claim or
    - Interim claims every 60 days
  - If BE during stay, submit
    - Interim claim(s) through BE date and, once this claim processed
    - No-payment claims in 60-day increments until final discharge or death

TOBs for LTCH Claims

- "One claim per stay" concept
  - 111 = Admission to discharge claim
  - 112 = First interim claim
  - 117 = Subsequent interim claim and adjustment claim
  - 118 = Cancel claim
  - 110 = No-payment claim
  - 12X = IP ancillary claim

TOB 111

- IP claim from admission to final discharge/death
  - Admission date = actual admission date
  - Statement from date = admission date
    - If payment window policy applies, report earliest OP DOS added to IP claim
    - If admission prior to Part A entitlement date, report Part A entitlement date
  - Statement through date = discharge/death date
    - Report PSC that accurately represents beneficiary's status as of this date
- Submit at final discharge/death
- Do not submit if BE during stay

TOBs 112 and 117 for Interim Billing

- 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
- You may submit if stay greater than 60 days
- You must submit if BE during stay

Interim Claims Less Than 60 Days

- Interim claims can include less than 60 days if beneficiary
  - Exhausts IP hospital benefit days
  - Discharged/transferred
  - Dies

Interim Claim Coding

- TOB 112 = first interim claim or 117 = subsequent interim claims
- Admission date = actual admission date
- Statement from date = admission date
  - If payment window applies, report earliest OP DOS added to claim
- Statement through date = 60th day, BE, discharge/death date
- PSC = 30 (still a patient) or appropriate PSC (if final claim)
- Claim change reason code = D3 (on TOB 117)
- Diagnosis codes = from admission to through date
- Procedure codes/dates = from admission to through date

TOB 117 for Adjustments

- IP adjustment claim
  - Submit to change or correct original claim
  - Becomes new claim by replacing original claim (debit/credit)
  - Requires one claim change reason code (reason for adjustment)
  - FISS Claim Change Reason or Condition Codes
    - D0 – E0 (except D5 and D6 for cancels)
    - Adjustments to final claims resulting in higher paying LTC-DRG must be submitted within 60 days of original claim's processed date (CC = D4)
  - How to Adjust a Claim
    - Reference original claim DCN in FL 64

TOB 118

- IP cancel claim
  - Submit to cancel original claim
  - Requires one claim change reason code (reason for cancel)
  - FISS Claim Change Reason or Condition Codes
    - D5 = Cancel-only to correct MBI or provider identification number
    - D6 = Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of OP bill containing services required to be included on IP bill)
  - How to Cancel a Claim
    - Reference original claim DCN in FL 64

TOB 110

- IP no-payment claim
- You must submit
  - For all noncovered IP stays
    - Except when beneficiary not enrolled in Medicare Part A (enrolled in Part B only)
  - At final discharge/death
  - In 60-day increments until final discharge/death

When to Submit TOB 110

- IP hospital benefit days exhausted
  - At admission
  - During stay
    - You must submit interim claim through BE date first
- LOC noncovered
  - At admission and for entire stay
    - Claim coding for admission denials (not R&N)
      - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.2 E
    - If care becomes covered during stay, cancel TOB 110s, submit corrected claims
      - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.1

TOB 12X

- IP ancillary claim for services rendered to inpatients
  - Submit under Part B when Part A can't pay for IP stay
  - Report revenue codes, units, charges, LIDOS (FL 45), CPT/HCPCS codes
    - IP stay denied not R&N
      - Billable services: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1
      - Non-billable revenue codes: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.1
    - If no Part A or IP hospital benefit days exhausted
      - Billable services: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2
      - Non-billable revenue codes: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.2

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.
  - Example: Certain vaccines and administration
    - 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
  - For DOS, use discharge date or BE date
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2

One-Day Payment Window Policy

Policy Overview

- Applies when payment can be made on Part A claim
  - **Admitting hospital** reports on its IP claim
    - OP **diagnostic** services it rendered on
      - Admission date and/or
      - Day prior to admission date
    - OP **nondiagnostic** services it rendered on
      - Admission date
      - Day prior to admission date unless LTCH determines **not related** to stay
        - If not related to stay, you may submit separate OP claim with **CC 51**

Admitting Hospital

- Admitting hospital includes any entity that is either
  - Wholly-owned or wholly-operated by LTCH or
  - Under arrangement with LTCH to provide services to beneficiary
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Sections 90 and 90.7.1

OP Diagnostic Services

- Defined by revenue and CPT/HCPCS codes on CMS' diagnostic services list
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.3

OP Nondiagnostic Services

- Defined by revenue and CPT/HCPCS codes not on CMS' diagnostic services list
- Submit separately from IP claim on OP claim if
  - Rendered on day prior to admission date and
  - LTCH attests **not related** to stay by reporting CC 51
    - **CC 51 = Services clinically distinct or independent from reason for IP admission**
      - You must have documentation to support decision
      - Claim may be subject to subsequent review
      - Claim subject to our one-year timely filing guideline

Reporting OP Services on IP Claim

- When you report applicable OP services on IP claim, include
  - Revenue code(s) and charges
  - Procedure(s) and associated date(s)
  - Diagnosis code(s)
  - Actual IP admission date and
  - Statement from date = earliest OP DOS added to claim

Admitted Before Part A Entitlement Date

Beneficiary Admitted to LTCH Prior to Part A Medicare Entitlement Date

- Per Inpatient Admission Prior to Medicare Entitlement Job Aid:
  - Admission date = actual admission date
  - Statement covers period = Part A effective date to discharge date
  - Covered days (VC 80) = days in statement covered period
  - Accommodation days/units (R&B revenue codes) = VC 80 days
  - Revenue codes = admission to discharge
  - Charges = admission to discharge except R&B prior to Part A
  - Diagnosis codes = admission to discharge
  - Procedure codes = admission to discharge
  - Remarks to indicate beneficiary's Part A effective date

Services Rendered Under Arrangement

Did You Know

- All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangement.
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 10.4

Services to Inpatients Under Arrangement

- As general rule, a hospital
  - Admits beneficiary as IP but he/she needs services it could not provide
  - Sends IP beneficiary to another facility for those services
    - Other facility renders services as OP; beneficiary returns to hospital same day
  - Reimburses other facility for OP services
    - Other facility submits their claim to hospital; not to Medicare
  - Submits IP claim with
    - Revenue codes for services it rendered and charges
    - Revenue codes for services other facility rendered under arrangement and cost
      - Includes cost for transportation; does not report revenue code 0540

Under Arrangement Example

- LTCH example
  - Beneficiary in LTCH but requires MRI LTCH cannot provide
  - LTCH sent beneficiary to ACH for MRI on 5/15/2025 at 8 a.m. by ambulance
  - Beneficiary returns to LTCH same day 5/15/2025 at 1 p.m.
- LTCH action
  - Pay ACH for MRI
  - Pay transportation provider for ambulance
  - On IP claim, report revenue code for MRI with total cost for MRI and transportation
- **Note:** This is also an example of LTCH one-day interruption

Did You Know…

- LTCHs must follow CMS' billing guidelines for three-day or less interrupted stays as well as for greater than three-day interrupted stays.
  - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 150.9.1.2

Coding for Noncovered Care

Beneficiary Received Noncovered Care During Stay

- All IP claims must include claim coding for any periods of time during which beneficiary at noncovered LOC
  - OC 31 and date
    - Date provider notified beneficiary
  - VC 31 and amount
    - Amount of charges provider may bill beneficiary for hospitalization not R&N
  - OSC 76 with from/through dates
    - Beneficiary liability
    - Period of noncovered care for which you may charge beneficiary
      - Beneficiary notified in writing prior to “from” date of this period

Beneficiary Received Noncovered Care During Stay (continued)

- OSC 77 and from/through dates
  - Provider liability; utilization
  - Period of noncovered care for which you are liable (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 and from/through dates
  - Provider liability; no utilization
  - Period of noncovered care for which you are liable (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 Stay in LTCH

One-Day IP LTCH Stay

- May occur in between two IP stays at same ACH
  - Beneficiary
    - IP in ACH
    - Transferred to LTCH on same day
    - Readmitted to same ACH by midnight on same day
  - LTCH
    - Contacts ACH to determine how they will bill Medicare
    - Submits one-day stay to
      - **ACH** (to be paid under arrangement) if ACH determines two stays related and will submit one combined claim to Medicare
      - **Medicare** if ACH determines two stays not related and will submit two separate claims to Medicare

One-Day IP LTCH Stay (continued)

- May occur in between two IP stays at different facilities
  - Beneficiary
    - IP in facility
    - Transferred to LTCH on same day
    - Admitted to another IP facility by midnight on same day
  - LTCH
    - Submits one-day stay to Medicare

One-Day IP LTCH Stay Billing

- To submit one-day LTCH stay, report
  - TOB 111
  - Same admission, from and through date(s)
  - CC 40 (same-day transfer)
  - One noncovered day
  - Covered services/charges

Payment, Benefit Days, BE and HCOs

Payment Under LTCH PPS

- Payment of IP services made via LTC-DRG if discharge excluded from site neutral payment rate
  - Beneficiary must have at least enough benefit days to exceed short-stay outlier (SSO) threshold and LOS must exceed SSO threshold
    - SSO threshold = 5/6 of LTC-DRG's ALOS
  - Example:
    - If ALOS for specific LTC-DRG = 12 days
      - SSO threshold (5/6 of ALOS) = ten days
    - LTC-DRG payment made when
      - Beneficiary has at least 11 benefit days, and
      - LOS at least 11 days

SSO Payment Policy and 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 = one day to 5/6 of ALOS for LTC-DRG case grouped to and LTC-DRG payment subject to SSO adjustment

SSO Payment

- Made when
  - Beneficiary does not have enough benefit days to exceed SSO threshold, and/or
  - LOS does not exceed SSO threshold
- Example:
  - If ALOS for specific LTC-DRG = 12 days
    - SSO threshold (5/6 of ALOS) = ten days
  - SSO payment made when
    - Beneficiary has ten or less benefit days, and/or
    - LOS ten days or less

HCO Payment Under LTCH PPS

- Additional payment for cases with extraordinarily high costs
  - Beneficiary must have benefit day for each R&N day in HCO period
    - Begins day after accumulated covered charges reach HCO threshold amount (amount is exceeded)
      - LTC-DRG + fixed loss amount
        - OC 47 and date HCO threshold exceeded may be needed

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 in LTCH only**
- Benefit period tracks use of benefit days

LTR Days – Special Policy for Use in LTCH

- Beneficiary can use LTR days to exceed SSO threshold if doesn't have enough regular benefit days to exceed it
  - Once started, must continue to use for each remaining day in stay even if no additional payment generated
- Example:
  - ALOS for LTC-DRG = 12 days
  - SSO threshold (5/6 of ALOS) = ten days
  - LOS = at least 11 days
  - If beneficiary has ten regular benefit days and five LTR days, we apply
    - All ten regular benefit days
    - At least one LTR day (if LOS = 11 days) but more (up to four) if LOS continues

Application of IP Hospital Benefit Days Under LTCH PPS

- Medicare uses unique methodology when applying benefit days to IP LTCH claim
  - We do not apply
    - Benefit days on a “day by day” basis
    - Regular benefit days and LTR days to same claim
      - Unless LTR days needed to exceed SSO threshold and/or for HCO period
  - We do apply LTR days if they are
    - All that remain at admission
    - Needed to exceed SSO threshold and/or for HCO period

BE

- Beneficiary used all IP hospital benefit days
  - Including LTR days
- BE date = Date beneficiary last had benefit day available
  - Reported on claim with OC A3

BE Date Affected by IP Hospital Benefit Day Application Under LTCH PPS

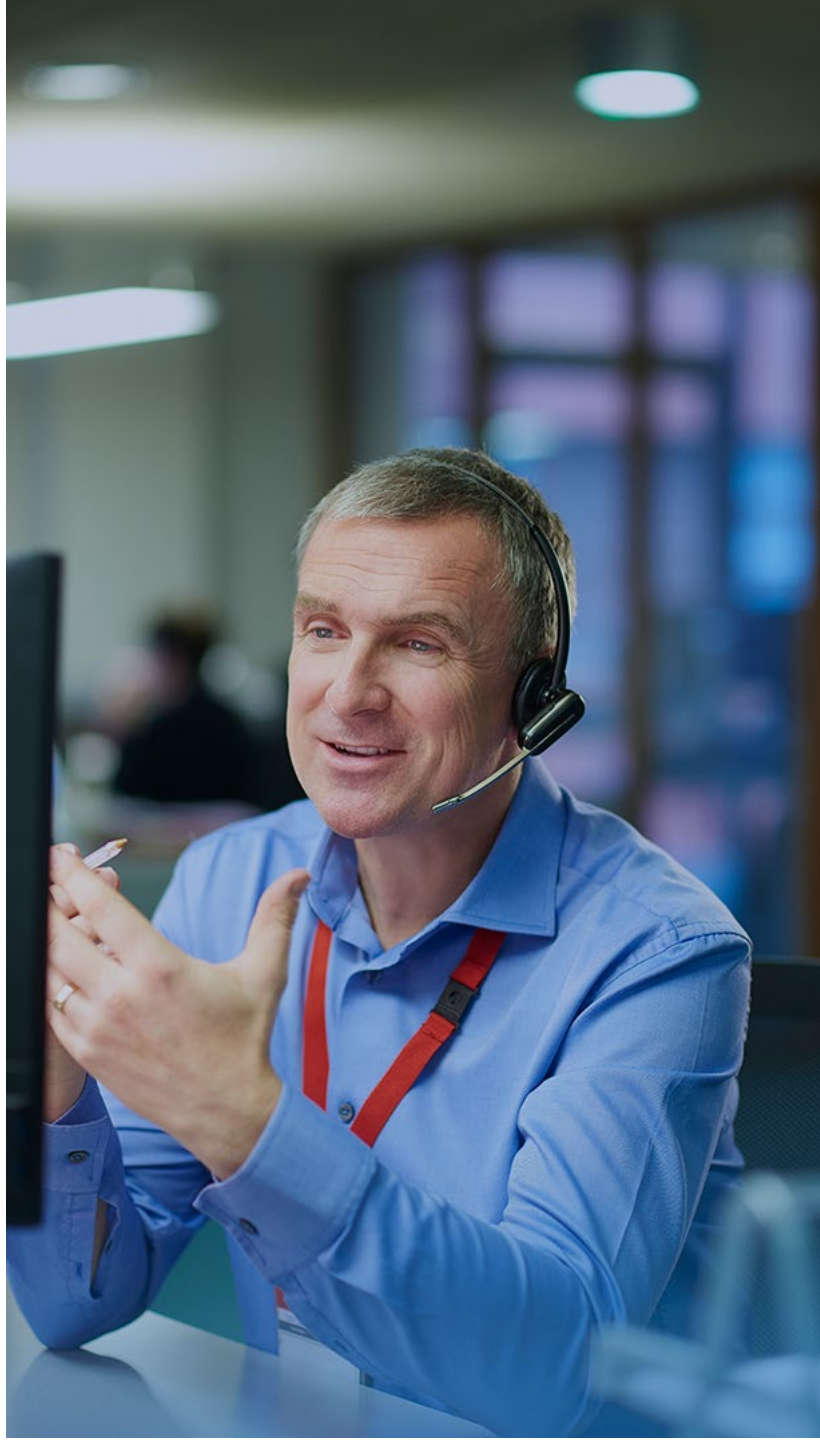
- BE date depends on whether beneficiary has enough benefit days to
  - Exceed SSO threshold
    - Whether or not he/she
      - Has enough regular (full and/or coinsurance) benefit days to exceed it
      - Needed to use LTR days to exceed it
  - Cover each R&N day in any HCO period
    - When claim qualifies for HCO

Inlier Days, Inlier Period and OSC 70

- Because we pay claim up to any HCO if beneficiary has enough benefit days to exceed SSO threshold
  - We may pay for days beneficiary doesn't have
    - Inlier days
      - If no HCO = days after last available IP hospital benefit day to end of stay
      - If HCO = days after last available IP hospital benefit day up to HCO
    - Inlier period; we apply OSC 70 and from/through dates
      - If no HCO = period between last available IP hospital benefit day and end of stay
      - If HCO = period between last available IP hospital benefit day and HCO period

Determining BE Date – Two Options

- You can determine BE date
  - Use Medicare benefit day information in CWF
    - HIPAA Eligibility Transaction System (HETS)
    - NGSConnex
- You can let us determine BE date



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

- Submit claim **through BE date you determined**
  - TOB = 112 if no prior interim claim or 117 if prior interim claim
  - Statement through date = BE date
  - PSC = 30
  - OC = A3 and BE date
- Upon receipt of claim, we
  - Review OC A3 date and determine if correct
  - If necessary, RTP claim with
    - Reason code 7A000 and remarks providing correct BE date and instructions to change statement through date to BE date (end/split/cut claim at BE date)
    - Reason code 37036 or 37045 asking for OC 47 and date HCO threshold exceeded

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

- Submit claim **through next 60-day interim billing period**
  - TOB = 112 if no prior interim claim or 117 if prior interim claim
  - Statement through date = end of applicable 60-day period
  - PSC = 30
  - All R&N days as covered up to 150 regardless of benefit days in CWF
    - For days above 150, report as noncovered but associated charges as covered
- Upon receipt of claim, we
  - Determine BE date
  - RTP claim with
    - Reason code 7A000 and remarks providing correct BE date and instructions to change statement through date to BE date (end/split/cut claim at BE date)
    - Reason code 37036 or 37045 asking for OC 47 and date HCO threshold exceeded if necessary

RTP Reason Codes 37036 and 37045 for HCO Claims

- Claim's covered charges exceed HCO threshold amount and beneficiary
  - Does not have enough regular benefit days to cover R&N days or
  - Has only LTR days but not enough to cover R&N days
- Reason codes
  - 37036 = Not enough benefit days for each medically necessary day and covered charges exceed HCO threshold amount
  - 37045 = LTR days can only be present with regular benefit days when OC 47 and date present
- LTCH Action
  - Add OC 47 and date = day after date HCO threshold amount reached

Determining OC 47 Date

- View HCO threshold amount on MAP1716 (page 6 in FISS DDE)
- Add claim's daily covered charges
  - Start with day one
  - Continue each day until your charges reach HCO threshold amount
    - Exclude charges for days in noncovered OSCs
- Note date daily covered charges reach HCO threshold amount
- Report OC 47 and date on claim
  - Date HCO threshold amount exceeded (day after date HCO threshold amount reached); cannot be equal to or during noncovered OSCs
- Correct units/charges for noncovered services if BE occurs

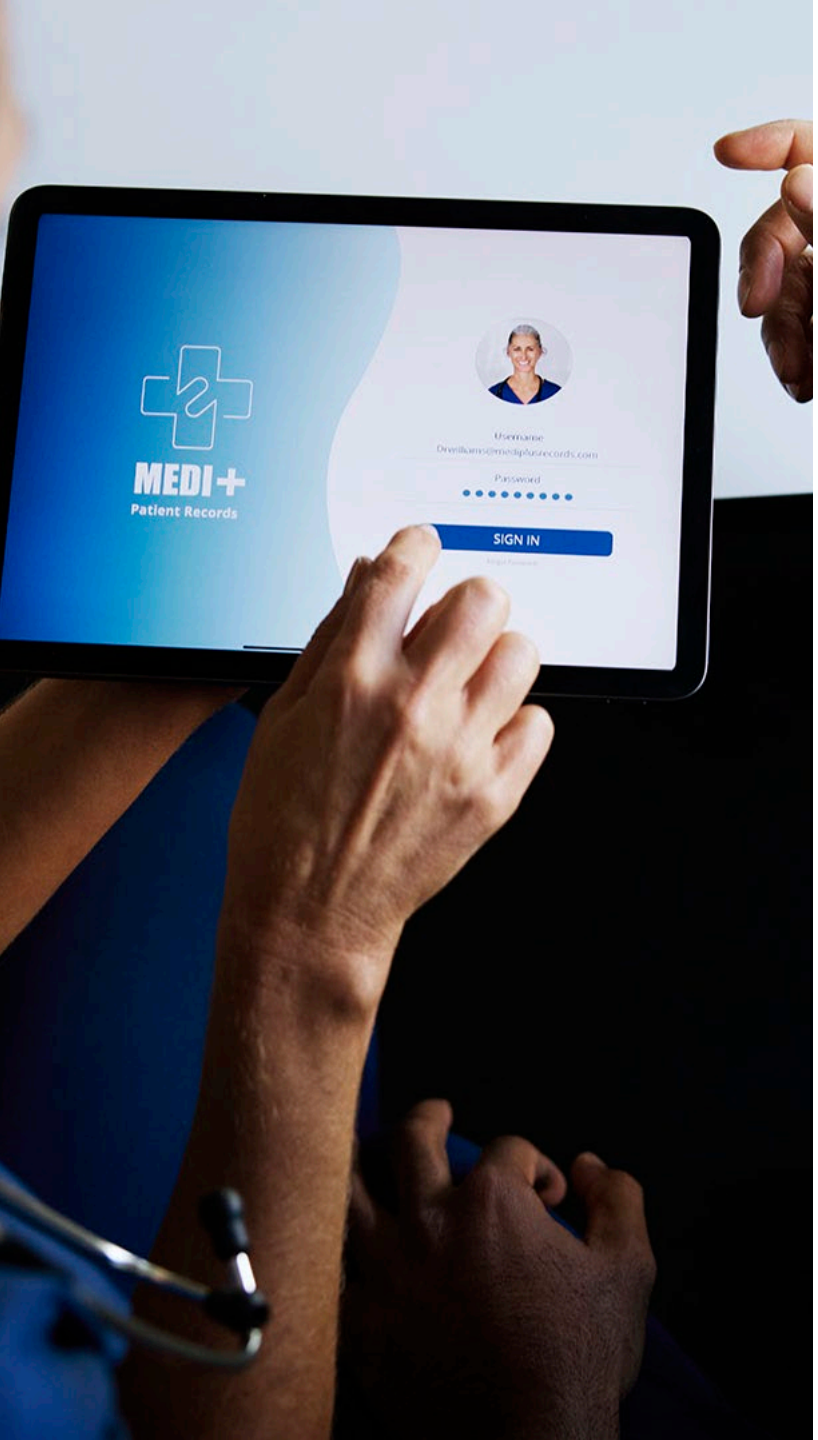
No-Payment Claims Following BE Claim

- Wait for BE claim (TOB 112 or 117) to finalize
- First no-payment claim after BE
  - TOB = 110
  - Admission date = Date of admission
  - Statement from date = Day after through date 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 (continued)

- Subsequent no-payment claims after BE
  - TOB = 110
  - Admission date = Date of admission
  - Statement from date = Day after through date 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

MAO Plan Enrollees



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

- Plan effective at admission responsible for entire IP stay
  - Traditional Medicare responsible
    - If patient enrolled in traditional Medicare at admission
  - MAO plan responsible
    - If patient enrolled in MAO plan at admission

Teaching LTCH Bills Traditional Medicare for MAO Plan Enrollee

- Submit IP informational claims to us to receive payment for DGME or N&AH via cost report
  - After billing MAO plan, submit IP informational claim to us and report
    - Covered TOB 11X (unless N&AH only; submit TOB 110)
    - Covered days/charges (unless N&AH only; submit noncovered days/charges)
    - CCs 04 and 69
    - Medicare as first payer (obtain MBI from patient); not as MSP claim
    - All other required claim elements
- We reject claims with
  - Reason code 37574 and pay DGME via cost report
  - Reason code 39934 and pay N&AH via cost report

Non-Teaching LTCH Bills Traditional Medicare for MAO Plan Enrollee

- Submit IP informational claims to us for DSH calculation
  - After billing MAO plan, submit IP claim to us and report
    - Covered TOB 11X
    - Covered days/charges
    - CC 04
    - Medicare as first payer (obtain MBI from patient); not as MSP claim
    - All other required claim elements for claim
- We processes claims with reason code 3719C

What You Should Do Now

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

References and Resources

National Government Services

- Acronym Search Tool
- ASCA Requirements for Paper Claim Submission
- Claim's Department addresses
- EDI and How it Works
- FISS Claim Change/Condition Reason Codes
- *FISS DDE Provider Online Guide*
- Hospital Billing for Beneficiaries Enrolled in Option Code C Medicare Advantage Organization Plans

National Government Services (continued)

- How to Cancel a Claim
- How to Adjust a Claim
- Inpatient Admission Prior to Medicare Entitlement Job Aid
- NGSConnex
- Long-Term Care Hospitals: How to Request Adjustments of Claims Paid at the Site Neutral Rate
- Prepare and Submit a Medicare Secondary Payer Claim
- What All Facilities Need to Know About the Long-Term Care Hospital Three-Day or Less Interrupted Stay Policy

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
    - Section 10.1, Reasonable and Necessary Part A Hospital Inpatient Claim Denials
    - Section 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 Skilled Nursing Facilities

CMS IOM Publications (continued 1)

- 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Sections
    - 50.2.1, Inpatient Billing From Hospitals and SNFs
    - 70, Time Limitations for Filing Part A and Part B Claims
    - 90, Patient is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
  - Chapter 3, Sections
    - 10.4, Patient of Nonphysician Services for Inpatients
    - 20.3, Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients (change this to correct section for LTCHs?)
    - 20.7.4, Cost Outlier Bills With Benefits Exhausted
    - 40.2.1, Noncovered Admission Followed by Covered Level of Care

CMS IOM Publications (continued 2)

- 100-04, *Medicare Claims Processing Manual*
  - Chapter 3, Sections
    - 40.2.2, E Charges to Beneficiaries For Part A Services (Admission Denied)
    - 40.2.5, Repeat Admissions
    - 40.3, Outpatient Services Treated as Inpatient Services
    - 150, Long Term Care Hospitals (LTCHs) PPS
    - 150.9.1.2, Interrupted Stays
    - 150.13, Billing Requirements Under LTCH PPS
    - 150.17, Benefits Exhausted
    - 150.19, Interim Billing
  - Chapter 4, Section
    - 10.12, Payment Window for Outpatient Services Treated as Inpatient Services

CMS IOM Publications (continued 3)

- 100-04, *Medicare Claims Processing Manual*
  - 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, Hepatitis B Virus and COVID-19 Vaccines and Their Administration on Institutional Claims
  - Chapter 25
    - Section 75, General Instructions for Completion of Form CMS-1450 for Billing

CMS CRs

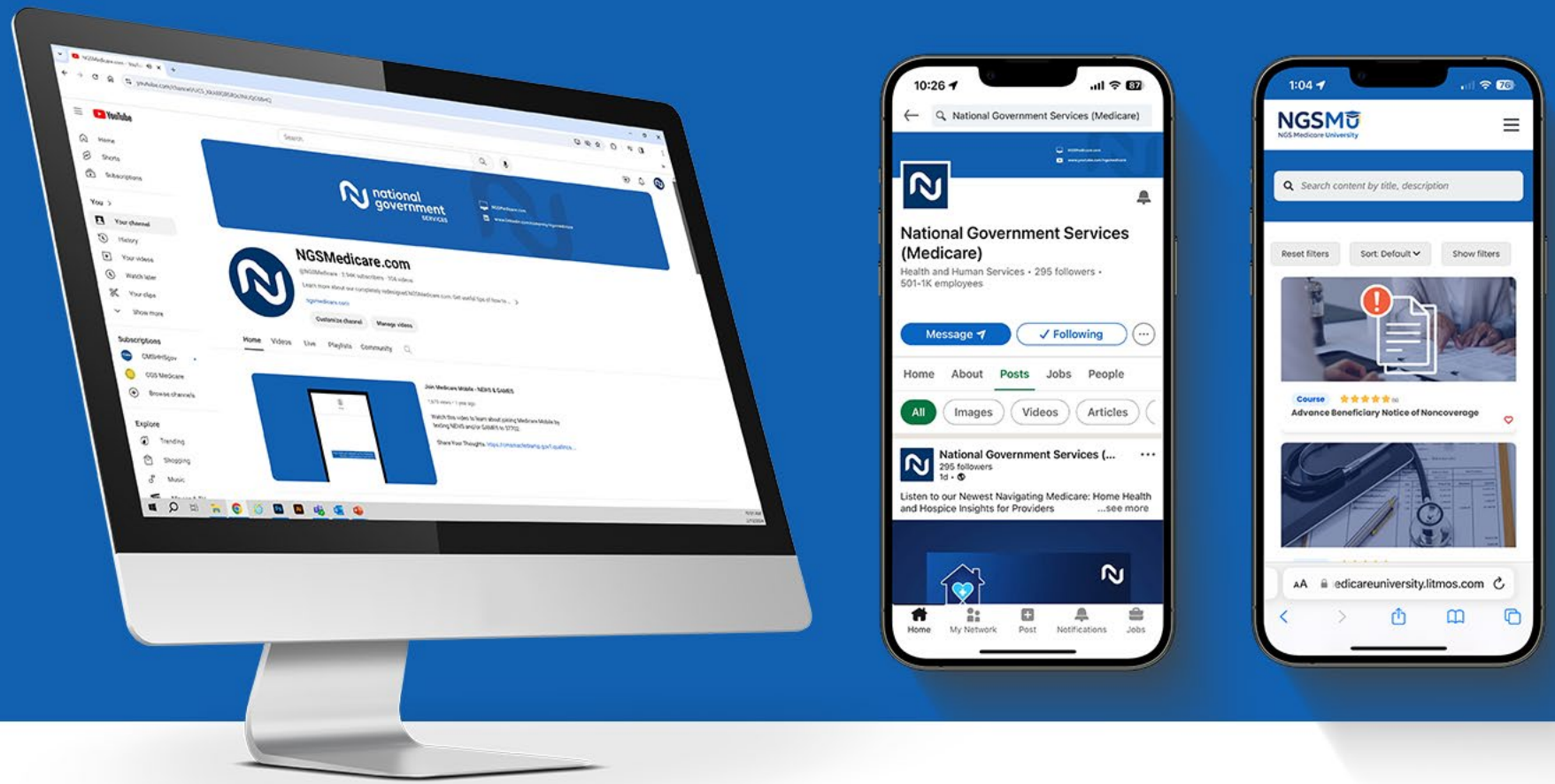
- CR2476, Payment to Hospitals and Units Excluded from Acute IPPS for DGME and N&AH Education for Medicare + Choice (M+C) Enrollees
- CR3389, Revision of CWF Editing for Same-Day, Same-Provider Acute Care Readmissions
- CR5474, Use of BE Day as Day of Discharge for Payment Purposes for IPF PPS and Clarification of Discharge for LTCH 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
- CR9015 Revised, Implementation of LTCH PPS Based on Specific Clinical Criteria

CMS Articles and Web Pages

- HIPAA Eligibility Transaction System (HETS)
- Long-Term Care Hospital PPS Web Pricer
- Long-Term Care Hospital PPS
- MLN® Booklet *Medicare Billing: CMS-1450 & 837I*
- MLN Matters® *SE1627: Further Information on the Implementation of LTCH PPS Based on Specific Clinical Criteria*
- FY 2025 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule –- CMS-1808-F
- FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule — CMS-1833-P Fact Sheet

Questions?

Thank you!



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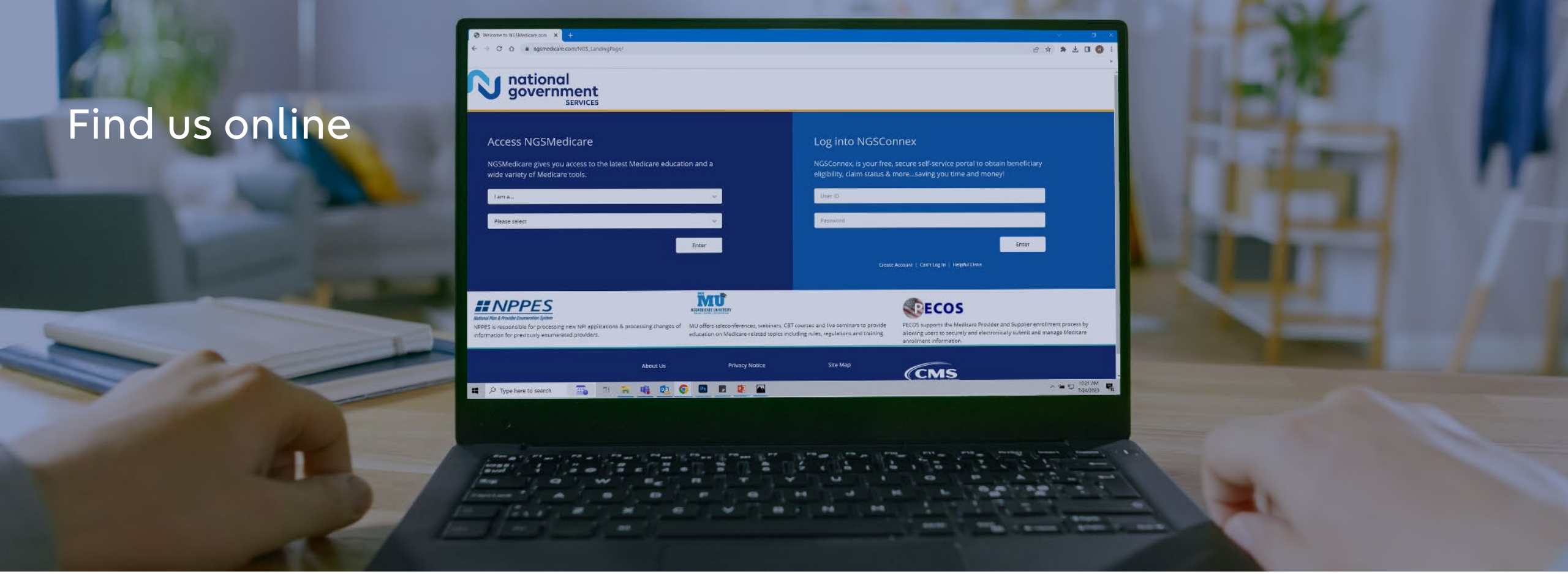

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