CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1895	**Date: August 4, 2017**
	Change Request 10185

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 14, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: System Changes to Implement Section 15010 of the 21st Century Cures Act, Temporary Exception for Certain Severe Wound Discharges from Certain Long-Term Care Hospitals (LTCHs)

I. SUMMARY OF CHANGES: This change request implements a temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs.

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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 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.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1895	Date: August 4, 2017	Change Request: 10185

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 14, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: System Changes to Implement Section 15010 of the 21st Century Cures Act, Temporary Exception for Certain Severe Wound Discharges from Certain Long-Term Care Hospitals (LTCHs)

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: Under the LTCH Prospective Payment System (PPS), for LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Medicare established two separate payment categories for LTCH patients upon discharge. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal payment rate and those cases not meeting specific clinical criteria are paid the site neutral payment rate (i.e., the lesser of an "Inpatient Prospective Payment System (IPPS)-comparable" payment amount or 100 percent of the estimated cost of the case).

In general, in order to be paid at the LTCH PPS standard Federal rate payment amount, an LTCH discharge must either: (1) have been admitted directly from a Medciare Subsection (d) Hospital (i.e., in general 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 a subsection (d) hospital (i.e., in general 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.

Section 15010 of the 21st Century Cures Act (Pub. L. 114-255) establishes an additional temporary exception from the site neutral payment rate for patients discharged from certain LTCHs with a severe wound, effective for discharges occurring during such LTCHs' cost reporting periods beginning during FY 2018 (that is, for such LTCHs' cost reporting periods that begin on or after October 1, 2017, and on or before September 30, 2018), as described in greater detail below in section (B)(1) of this CR.

B. Policy:
Under the provisions of section 15010 of the 21st Century Cures Act, in order for an LTCH's discharge to be excluded from the site neutral payment rate under this exception during its FY 2018 cost reporting period, the discharge must be:

(1) from an LTCH "identified by the last sentence of subsection (d)(1)(B)" of the Act;

(2) classified under MS LTC–DRG 602, 603, 539, or 540; and

(3) with respect to an individual treated by an LTCH for a severe wound.

The statute defines a "severe wound," for the purposes of the exception, as "a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula as identified in the claim from the long-term care hospital." The statute further defines a "wound" as "an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment."

1. Provider-level criteria: The statute specifies that the temporary exclusion for certain discharges from the site neutral payment rate is applicable to an LTCH that is "identified by the last sentence of subsection (d)(1)(B)" of the Act. CMS has interpreted the phrase in an identical manner to the equivalent phrase contained in Section 231 of the Consolidated Appropriations Act, 2016 (for more information on the implementation of that statute see CRs 9872 and 9599) to mean hospitals which were described in § 412.23(e)(2)(i) that meet the criteria of § 412.22(f) of the regulations, which are a group of LTCHs commonly referred to as "grandfathered hospitals-within- hospitals" (or grandfathered HwHs). (Note, an HwH is defined in the regulations at 42 CFR 412.22(e) as a hospital which occupies space in a building also used by another hospital or on the campus of another hospital.)

Section 412.22(f) requires that, in order to maintain grandfathered status, an HwH must continue to operate under the same terms and conditions including but not limited to number of beds. Therefore, in order to be eligible for this temporary exception, an LTCH must have participated in Medicare as an LTCH and was co-located with another hospital as of September 30, 1995, and **must currently meet the requirements of § 412.22(f)**. There are several reasons for which an LTCH described in § 412.23(e)(2)(i) may not currently meet the criteria in §412.22(f). For example, the LTCH may have more than one location, or the HwH may have increased beds after September 30, 2003 (we note these examples are not intended to be an exhaustive list of the reasons an LTCH may not meet the criteria in § 412.22(f)). Medicare Administrative Contractors (MACs) **must verify** that an LTCH described in § 412.23(e)(2)(i) **currently meets the criteria in §412.22(f)** in order for the LTCH to be eligible for this temporary exception from the site neutral payment rate for certain wound care discharges. This verification will be performed at the request of the LTCH. MACs may need to obtain additional information from the requesting LTCH in order to make the determination of whether the LTCH meets the criteria in §412.22(f).

Additional information on the requirement that grandfathered HwHs meet the criteria in § 412.22(f) can be found in the following IPPS rules: FY 1997 IPPS final rule (62 FR 46012); FY 2004 IPPS final rule (68 FR 45463),; May 22, 2008 LTCH PPS interim final rule with comment period (73 FR 29703); and FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43980).

For LTCHs that meet these requirements, the MAC will set the Temporary Relief Indicator field on the provider specific file (PSF) to a 'Y' to be effective of the start of the hospital's FY 2018 cost reporting period (that is, for such LTCH's cost reporting period that begins on or after October 1, 2017, and on or before September 30, 2018). (For example, for an LTCH with a calendar year cost reporting period a 'Y' will be entered in the Temporary Relief Indicator field effective for discharges occurring during its cost reporting period beginning on January 1, 2018 through December 31, 2018.) Upon expiration of this temporary statutory provision, the MAC will set the Temporary Relief Indicator field on the PSF to an 'N' to be effective the start of the hospital's FY 2019 cost reporting period (that is, the LTCH's cost reporting period that begins on or after October 1, 2018). (For example, a LTCH with a calendar year cost reporting period will no longer be eligible for this adjustment beginning with discharges occurring on or after January 1, 2019.)

2. Discharge-level criteria: The statutory temporary exclusion for certain discharges from the site neutral payment rate for certain LTCHs is applicable to discharges occurring in a qualifying LTCH's cost reporting period that begins during FY 2018, that was treated by a LTCH for a "severe wound." The statute defines a "severe wound" as "a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, or fistula, as identified in the claim from the long-term care hospital." The statute further defines a "wound" as "an injury involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment." To implement these definitions, we are using ICD-10 diagnosis codes on the claim we are using the list of ICD-10 diagnosis codes found on the CMS web site at https://www.cms.gov/Medicare/Medicare-Fee-for- Service-Payment/LongTermCareHospitalPPS/download.html which we used to implement Section 231 of the Consolidated Appropriations Act, 2016. Because the categories statutorily defined as "severe wounds" in the 21st Century Cures Act are identical to those which have been identified by specific ICD-10 diagnosis codes, we are using the same list. We note while that the 21st Century Cures Act did not include the "osteomyelitis" category which was present in the Consolidated Appropriations Act of 2016 provision, our

interpretation of that category is that it was wholly included in the category "fistula," which is included in the 21st Century Cures Act provision. We also note that the payer-only condition code "M4" will not be used as the categories "wound with morbid obesity" and "infected wound" were not included in the definition of "severe wound" in the 21st Century Cures Act.

Section 15010 additionally requires that the discharge that was treated by a LTCH for a "severe wound" be classified under MS–LTC–DRG 539, 540, 602, or 603.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10185.1	If requested by the hospital, Medicare contractors shall verify which LTCHs in their jurisdictions are grandfathered HwHs as described in Section (B)(1) (Provider Level Criteria) of this CR.	X								
10185.2	Medicare contractors shall input a 'Y' in the Temporary Relief Indicator field for grandfathered HwH LTCHs with an effective date of the beginning of the hospital's FY 2018 cost reporting period (i.e., the cost reporting period beginning on or after 10/01/2017 and before 10/01/2018).	X								
10185.2.1	Medicare contractors shall remove the 'Y' value in the Temporary Relief Indicator field for these hospitals with an effective date of the hospital's FY 2019 cost reporting period (i.e., the cost reporting period beginning on or after 10/01/2018 and before 10/01/2019).	X								
10185.3	Medicare contractors shall update their systems to add ICD-10 diagnosis code T81.4XXS to the list of codes in Attachment A of CR 9599, Transmittal 1675, that qualify for LTCH PPS standard federal rate payment under the temporary exception for severe wounds from certain LTCHs. Note: Code T81.4XXS shall have the same date parameters as in CR 9599.					X				
10185.4	Medicare contractors shall update their systems to remove ICD-10 diagnosis code T81.4XX from the list of codes in Attachment A of CR 9599, Transmittal 1675, that qualify for LTCH PPS standard Federal payment rate payment under the temporary exception for severe wounds from certain LTCHs.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10185.5	Medicare contractors shall notify Emily Lipkin at emily.lipkin@cms.hhs.gov when they have verified a hospital's status as a grandfathered HwH. Such notification shall include the hospital's name and Medicare Provider number.	X								
10185.6	Medicare contractors shall apply review code ‘00’ when the PSF Temporary Relief Indicator for an LTCH equals ‘Y’, one of the ICD-10 diagnosis codes listed in Attachment A of CR 9599 (including diagnosis code T81.4XXS from BR 10185.3) is present, the claim is classified under MS-LTC-DRG 539, 540, 602, or 603 and the through date or discharge date is on or after the start of the LTCH’s FY 2018 cost reporting period (that is, the LTCH’s cost reporting period that begins on or after October 1, 2017, and on or before September 30, 2018) and before the start of the LTCH’s FY 2019 cost reporting period (that is, the LTCH’s cost reporting period that begins on or after October 1, 2018), as described in Section (B)(1) (Provider Level Criteria) of this CR.					X				
10185.7	Medicare contractors shall reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after the start of the LTCH’s FY 2018 cost reporting period (that is, the LTCH’s cost reporting period that begins on or after October 1, 2017) through the implementation of this CR when the PSF Temporary Relief Indicator for an LTCH equals ‘Y’, one of the ICD-10 diagnosis codes listed in Attachment A of CR 9599 (including diagnosis code T81.4XXS from BR 10185.3) is present, and the discharge is classified under MS-LTC-DRG 539, 540, 602, or 603.	X								
10185.7.1	Medicare contractors shall reprocess claims within 60 days from the implementation date of this change request.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Emily Lipkin, emily.lipkin@cms.hhs.gov (For Policy Questions) , Cami DiGiacomo, cami.digiacomo@cms.hhs.gov (For claims processing questions)

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: 0