

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: MM9599 Revised Related Change Request (CR) #: CR 9599
Related CR Release Date: June 16, 2016 Effective Date: April 21, 2016
Related CR Transmittal #: R1675OTN Implementation Date: October 3, 2016

System Changes to Implement Section 231 of the Consolidated Appropriations Act, 2016, Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals (LTCHs)

Note: This article was revised on June 16, 2016, to reflect an updated Change Request (CR). The CR release date, transmittal number and link to the CR also changed. All other information remains the same

Provider Types Affected

This MLN Matters® Article is intended for Long-Term Care Hospitals (LTCHs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR9599 implements a temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs. Make sure your billing staffs are aware of this exception.

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 rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment (that is, the lesser of an “Inpatient

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

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 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.

Section 231 of the Consolidated Appropriations Act, 2016, establishes a temporary exception from the site neutral payment rate for certain patients discharged from certain LTCHs before January 1, 2017.

As implemented, this exception applies to discharges occurring on or after April 21, 2016, and prior to January 1, 2017, from LTCHs “identified by the amendment made by Section 4417(a) of the Balanced Budget Act of 1997” and “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Social Security Act when the individual discharged had a “severe wound.” The final payment for discharges that meet the statutory provider-level and discharge-level criteria as implemented by the Centers for Medicare & Medicaid Services (CMS) is based on the LTCH PPS standard Federal payment rate. This temporary statutory exception from the site neutral payment rate was implemented in an interim final rule with comment period (IFC) (published in the Federal Register on April 21, 2016).

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 amendment made by Section 4417(a) of the Balanced Budget Act of 1997.” As discussed in the IFC, CMS has interpreted the phrase to mean hospitals which are described in 42 CFR Section 412.23(e)(2)(i) that meet the criteria of Section 412.22(f), 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). Therefore, in order to be eligible for this temporary exception, an LTCH must have participated in Medicare as an LTCH and have been co-located with another hospital as of September 30, 1995, and must currently meet the requirements of Section 412.22(f).

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 the number of beds. There are several reasons for which an LTCH described in Section

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

412.23(e)(2)(i) may not currently meet the criteria in Section 412.22(f). For example, the LTCH may have more than one location, or the HwH may have increased beds after September 30, 2003 (CMS notes these examples are not intended to be an exhaustive list of the reasons an LTCH may not meet the criteria in Section 412.22(f)). MACs must verify that an LTCH described in Section 412.23(e)(2)(i) currently meets the criteria in Section 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 process will likely involve direct outreach to LTCHs in order to verify the required information. 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/RV 2010 LTCH PPS final rule (74 FR 43980).

The temporary statutory exclusion for certain discharges from the site neutral payment rate is further limited to grandfathered HwH LTCHs that are “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act. For purposes of this provision, “located in a rural area” refers to LTCHs that are currently located in a rural area as defined under § 412.503 (that is, located in any area outside an urban area, which is an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget)). (Information on the current labor market area geographic classifications used under the LTCH PPS is available in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50180 through 50185)).

Section 1886(d)(8)(E) of the Act provides for an urban IPPS hospital that is located in an urban area to be reclassified as a rural hospital if it submits an application in accordance with CMS’ established criteria and meets certain conditions (see Section 412.103). (Additional information on CMS’ policies for IPPS hospitals located in urban areas and that apply for reclassification as rural under § 412.103 can be found in the FY 2012 IPPS/ LTCH PPS final rule (76 FR 51595).) For the purpose of implementing the phrase “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act for the temporary statutory exclusion for certain LTCH discharges from the site neutral payment rate, CMS revised its regulations to “borrow” the existing rural reclassification process for urban IPPS hospitals under § 412.103 and to allow grandfathered HwH LTCHs (defined above) to apply to their CMS Regional Office for treatment as being located in a rural area for the sole purpose of qualifying for this temporary exclusion from the application of the site neutral payment rate.

For grandfathered HwH LTCHs that qualify for this temporary exception for certain wound care discharges from the site neutral payment rate by applying for and satisfying the criteria to reclassify as rural under the provisions of § 412.103, the exception from the site neutral payment rate for qualifying discharges is effective beginning the effective date of the rural reclassification (that is, as of the filing date of the application as specified in § 412.103).

Note: This policy only allows grandfathered HwH LTCHs to apply for this reclassification, and the rural treatment only extends to this statutory temporary exception for certain wound care discharges from the site neutral payment rate, and reclassifying grandfathered HwH LTCH will not be treated as rural under the LTCH PPS for any other reason including, but not limited to, the 25 percent policy and wage index). Any rural treatment under the

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

provisions of § 412.103 for a grandfathered HwH LTCH will expire at the same time as this temporary provision (that is, December 31, 2016).

Discharge-Level Criteria:

As implemented, the statutory temporary exclusion for certain discharges from the site neutral payment rate for certain LTCHs is applicable to discharges occurring on or after April 21, 2016, and on or before December 31, 2016, that had a “severe wound.” The statute defines a “severe wound” as, “a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity as identified in the claim from the long-term care hospital.”

To implement this statutory definition, CMS has defined wound as “an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.” To implement this definition, CMS is using ICD-10 diagnosis codes on the claim where ICD-10 diagnosis codes contain sufficient specificity for this purpose or through the use of a payer-specific condition code where the ICD-10 diagnosis codes lack sufficient specificity for this purpose.

For six of the eight statutory categories included in the definition of “severe wound” (stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, fistula, and osteomyelitis), CMS is using the list of ICD-10 diagnosis codes found on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html>.

Note: Under the CMS definition of wound, the ICD-10 diagnosis codes used to identify severe wounds in the osteomyelitis category are also part of the ICD-10 diagnosis codes used to identify severe wounds in the fistula category so no separate identification of ICD-10 codes for osteomyelitis is necessary.

The remaining two statutory categories included in the definition of “severe wound” (infected wound and wound with morbid obesity) lack ICD-10 diagnosis codes with sufficient specificity to identify the presence of a “severe” wound, so claims containing such wounds will be identified by using specified “payer-only” condition codes. For the purposes of this provision, CMS has defined a “wound with morbid obesity” as “a wound in those with morbid obesity that require complex, continuing care including local wound care occurring multiple times a day” and an “infected wound” as “a wound with infection requiring complex, continuing care including local wound care occurring multiple times a day.” If an LTCH has a discharge meeting this definition of “wound with morbid obesity” or “infected wound” the LTCH will inform its MAC, and the MAC will then place the payer-only condition code “M4” on the claim for processing.

The presence of that designated payer-only condition code on the claim for qualifying rural (or reclassified rural) grandfathered HwH LTCHs will generate a standard Federal payment rate payment for the claim (that is, exclusion from the site neutral payment rate) consistent with this statutory provision in the LTCH PPS Pricer and claims processing system.

MACs will reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016 through December 31, 2016, when the Temporary

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

Relief Indicator for an LTCH on the Provider Specific File (PSF) equals ‘Y’ and one of the ICD-10 diagnosis codes listed on the CMS website mentioned above is present. The claims shall be reprocessed within 60 days from the implementation date of this change request. MACs will adjust impacted LTCH inpatient claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through December 31, 2016, processed prior to implementation of CR9599 or after when brought to the attention of the MAC by a qualifying LTCH.

Note: Claims for LTCHs which are treated as rural for the purposes of this provision will be reprocessed with a through date (for interim claims) or a discharge date (for final claims) on or after the effective date of the rural reclassification.

Additional Information

The official instruction, CR9599 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1675OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Document History

Date of Change	Description
June 16, 2016	The article was revised to reflect an updated CR. The CR release date, transmittal number and link to the CR also changed. All other information remains the same
April 30, 2016	Initial Article release

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.