

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



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Long Term Care Hospital Prospective Payment System

PAYMENT SYSTEM SERIES



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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Long Term Care Hospital Prospective Payment System (LTCH PPS) topics:

- ❖ LTCH certification
- ❖ MS-LTC-DRG patient classification
- ❖ Site neutral payment rate
- ❖ Payment policy adjustments
- ❖ Payment updates
- ❖ LTCH QRP
- ❖ Resources

When “you” is used in this publication, we are referring to LTCHs.

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LTCH Certification

LTCHs are certified under Medicare as short-term acute care hospitals and generally treat medically complex patients who require long-stay hospital-level care. For Medicare payment purposes, LTCHs are generally defined as having an average inpatient Length of Stay (LOS) greater than 25 days.

MS-LTC-DRG Patient Classification

The LTCH PPS uses MS-LTC-DRGs as a patient classification system. The MS-LTC-DRGs are the same Medicare Severity Diagnosis-Related Groups (MS-DRG) the Centers for Medicare & Medicaid Services (CMS) uses under the Inpatient Prospective Payment System (IPPS), weighted to reflect the different resources used by LTCHs. Each patient stay is grouped into an MS-LTC-DRG based on:

- ❖ Diagnoses (including secondary diagnoses)
- ❖ Procedures performed
- ❖ Age
- ❖ Gender
- ❖ Discharge status

Each MS-LTC-DRG has a predetermined Average Length of Stay (ALOS), which is the typical LOS for a patient classified to the MS-LTC-DRG. CMS updates the ALOS annually based on the latest available LTCH discharge data. Under the LTCH PPS, if the discharge is excluded from the site neutral payment rate, you are paid for each Medicare patient based on the MS-LTC-DRG to which that patient's stay is grouped. This reflects the typical resources used for treating such a patient. Medicare pays cases assigned to an MS-LTC-DRG based on the Federal payment rate, including any payment and policy adjustments.

Site Neutral Payment Rate

For cost reporting periods beginning on or after October 1, 2015, LTCH discharges that do not meet specific criteria will be paid at a new site neutral payment rate. The site neutral payment rate is generally the lower of:

- ❖ The IPPS comparable per diem amount (as calculated under our SSO policy)
- ❖ The estimated costs of the case (calculated by multiplying the allowable charges by the LTCH's Cost-to-Charge Ratio [CCR])

For a discharge to be excluded from the site neutral payment rate and paid based on the standard Federal payment rate:

- ❖ The discharge must not have a principal diagnosis in the LTCH of a psychiatric diagnosis or rehabilitation as indicated by the grouping of the discharge into one of 15 "psychiatric and rehabilitation" MS-LTC-DRGs (MS-LTC-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946).

- ❖ The discharge must have been immediately preceded by a Subsection (d) hospital discharge. "Immediately preceded" means that the LTCH admission occurred within 1 day of the Subsection (d) hospital discharge based on the admission date on the LTCH claim and the discharge date on the Subsection (d) hospital claim.
- ❖ The patient discharged from the LTCH must have either:
 - Spent at least 3 days in an intensive care unit during the immediately preceding Subsection (d) hospital stay. Discharges that meet this criteria are identified by the use of revenue center codes 020x and 021x on the Subsection (d) hospital discharge claim.
 - Received at least 96 hours of respiratory ventilation services during the LTCH stay that are generally identified by using International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) code 5A1955Z on the LTCH claim.
- ❖ For discharges occurring April 21, 2016, through December 31, 2016, the patient is treated for a severe wound and is discharged from a grandfathered LTCH Hospital-within-Hospital (HwH) located in a rural area or treated as being located in a rural area. To find the list of severe wounds by category identified by ICD-10 code, visit [CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html). Discharges that meet the definition of infected wound and wounds with morbid obesity are identified by using payor-only condition codes.

Discharges meeting these criteria are paid based on the standard Federal payment rate.

Payment Policy Adjustments

This section discusses the 25 percent threshold rule, SSO, high cost outlier, fixed-loss amounts, and interrupted stay payment policy adjustments (unless otherwise noted, these policies apply to both site neutral and standard Federal payment rate discharges).

Twenty-Five Percent Threshold Rule

These provisions apply to the 25 percent threshold rule:

- ❖ In fiscal year (FY) 2005, a special payment adjustment policy, commonly called the 25 percent threshold rule, was finalized. As defined by Code of Federal Regulations (CFR) at 42 CFR 412.534, it applied only to discharges from LTCH HwHs or satellites of an LTCH co-located with a host hospital or on the campus (any facility within 250 yards of the hospital) that had been admitted from the co-located hospital. Payments were adjusted for certain discharges for cost reporting periods in which more than 25 percent of the LTCH HwH's or LTCH satellite's discharges were admitted from its co-located host hospital. Specifically, after the 25 percent payment threshold was crossed, the net payment amount for the discharges occurring beyond the threshold was based on the lesser of a payment based on the MS-LTC-DRGs or an amount equivalent to what Medicare would have otherwise paid under the IPPS. In special situations (such as admissions from rural and urban single or Metropolitan Statistical Area [MSA]-dominant hospitals), the payment threshold was between 25 percent and 50 percent, set as the host's percentage of total Medicare discharges in the MSA for like hospitals.
- ❖ For cost reporting periods beginning on or after July 2007, the 25 percent payment threshold rule was expanded to include all LTCHs (such as free-standing and grandfathered co-located LTCHs) that admitted patients from any hospital with which the LTCH or LTCH satellite was not co-located. After the threshold was crossed, payments were adjusted for certain discharges for cost reporting periods in which more than 25 percent of the LTCH HwH's or LTCH satellite's discharges were admitted from any hospital other than a hospital with which it was co-located. Specifically, the net payment amount for the discharges occurring beyond the threshold was based on the lesser of a payment based on the MS-LTC-DRGs or an amount equivalent to what Medicare would have otherwise paid under the IPPS.
- ❖ For cost reporting periods beginning on or after October 1, 2007, and before October 1, 2012 (the increase also applied to grandfathered LTCH satellites effective for cost reporting periods beginning July 1, 2007, and before July 1, 2012), under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and amended by the American Recovery and Reinvestment Act of 2009 and the Affordable Care Act:
 - Raised the payment threshold to 50 percent, in special situations, for LTCH HwHs and LTCH satellites regulated under the original 25 percent threshold rule for FY 2005 and transitioned into the full threshold payment adjustment effective for cost reporting periods beginning on or after October 1, 2007, and before October 1, 2012 (the increase also applied to grandfathered LTCH satellites effective for cost reporting periods beginning July 1, 2007, and before July 1, 2012).
 - Raised the payment threshold to 75 percent for urban single hospitals or MSA-dominant referring hospitals effective for cost reporting periods beginning on or after October 1, 2007, and before October 12, 2012.
 - Exempted freestanding LTCHs and grandfathered HwHs in the CFR at 42 CFR 412.536 from the percentage thresholds for 5 years for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2012.

- Delayed application of the 25 percent payment provision for co-located provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located as of December 29, 2007.

The statutory moratorium was extended under the Pathway to SGR Reform Act of 2013 to end July 1, 2016, or October 1, 2016, as applicable. The Pathway to SGR Reform Act also permanently excepted certain grandfathered co-located LTCHs from the 25 percent threshold policy.

A revised streamlined 25 percent threshold policy, which is set forth at 42 CFR 412.538, is effective for discharges occurring on or after October 1, 2016, in LTCHs' cost reporting periods beginning after the expiration of the statutory moratorium. The sunset of original 25 percent threshold policies at 42 CFR 412.534 and 42 CFR 412.536 coincides with when the LTCH becomes subject to the revised streamlined 25 percent threshold policy at 42 CFR 412.538. Under the revised policy, an LTCH's compliance with the 25 percent threshold policy is determined based on the LTCH as a whole rather than whether each individual location of an LTCH is in compliance with the policy. Special treatment for rural LTCHs as well as LTCHs located in MSA-dominant areas remain; however, for LTCHs with multiple locations, all locations must be in rural or MSA-dominant areas to be subject to the increased threshold.

These discharge payments are not subject to the 25 percent threshold policy adjustment (you are eligible for the full per-discharge payment under the LTCH PPS):

- ❖ If a patient transferred from an acute care hospital that already qualifies for outlier payments, the admission will not count as part of the LTCH's allowable percentage from that hospital.

- ❖ If the LTCH exceeds its threshold during a cost reporting year, the LTCH discharges admitted from the admitting hospital prior to reaching the 25 percent (or applicable) threshold are paid an otherwise unadjusted payment. The 25 percent payment threshold policy adjustment is only made for discharges after the threshold is crossed.
- ❖ Subclause (II) LTCHs as described in Section 1886(d)(1)(B)(iv)(II) of the Social Security Act.
- ❖ Grandfathered HwHs LTCHs as described in the Pathway to SGR Reform Act.

SSO

The SSO, which assists in preventing inappropriate payment for cases that do not have a full episode of care, is an adjustment to the Federal payment rate for LTCH stays that are generally much shorter than the ALOS for a MS-LTC-DRG. An SSO payment adjustment to the standard Federal payment rate may occur when a patient:

- ❖ Experiences an acute condition that requires urgent treatment or requires more intensive rehabilitation, and you then discharge the patient to another facility
- ❖ Does not require the level of care provided in an LTCH, and you then discharge the patient to another facility
- ❖ Discharges to his or her home
- ❖ Dies within the first several days of admission to an LTCH
- ❖ Exhausts benefits during the LTCH stay (see the SSO Payments When the Patient's Benefits Exhaust During an LTCH Stay section for more information about exhausted benefits)

An adjustment applies when the LOS ranges from 1 day through 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped, and your MS-LTC-DRG payment is subject to SSO adjustment.

An adjustment is not applied when the LOS is more than 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped, and you receive the full MS-LTC-DRG payment.

This policy does not apply to site neutral discharges.

Note: If the ALOS for a particular MS-LTC-DRG is 30 days, the SSO policy applies to stays that are 25 days or less in length (5/6 of 30 days = 25 days).

Medicare pays an SSO case using the least of one of these case-level adjustment calculation methods:

- 1) The full payment for the MS-LTC-DRG assigned to the case.
- 2) An amount that is 120 percent of the MS-LTC-DRG per diem. To calculate the per diem, divide the full MS-LTC-DRG payment by the ALOS for the MS-LTC-DRG and multiply by the actual LOS of the case.
- 3) An amount that is 100 percent of the estimated cost of the case, which is calculated using the provider specific CCR.
- 4) For SSO discharge dates:
 - On or before December 28, 2012 – A blend of an amount comparable to what Medicare would otherwise pay under the IPPS, calculated as a per diem and capped at the full IPPS comparable amount, and 120 percent of the MS-LTC-DRG per diem amount.

- On or after December 29, 2012 – One of these amounts:
 - When the LOS is greater than the IPPS-comparable threshold, which is one standard deviation from the geometric average LOS for the same MS-DRG under the IPPS, for the MS-LTC-DRG assigned to the case – A blend of an amount comparable to what Medicare would otherwise pay under the IPPS, calculated as a per diem and capped at the full IPPS comparable amount, and 120 percent of the MS-LTC-DRG per diem amount.
 - When the LOS is equal to or less than the IPPS comparable threshold for the MS-LTC-DRG assigned to the case – An IPPS comparable amount, calculated on a per diem basis, capped at an amount comparable to but not exceeding what would have been a full payment under the IPPS.

SSO Payments When the Patient’s Benefits Exhaust During an LTCH Stay

Medicare only pays for covered benefit days until the LOS triggers a full MS-LTC-DRG payment. In other words, a patient’s remaining amount of benefit days and the length of a hospital stay can affect LTCH payment, resulting in an SSO payment adjustment. These tables provide examples of SSO payments for patients whose benefits exhaust.

When Benefits Exhaust and LOS Is Below the MS-LTC-DRG Threshold

IF...	THEN...	EXAMPLE
The patient uses all regular benefit days for an episode during an LOS that does not reach the SSO threshold for an MS-LTC-DRG.	The patient is liable for any non-covered days. You will receive an SSO payment for the patient’s covered hospital stay.	The MS-LTC-DRG SSO threshold is 25 days, and the patient’s LOS is 20 days. You will receive an SSO payment. Patient benefit days end on day 15. You will be paid only the 15 covered days under the short-stay policy. The patient is liable for days 16 through 20 of the stay.

When Benefits Exhaust and LOS Exceeds the MS-LTC-DRG Threshold

IF...	THEN...	EXAMPLE
The patient uses all benefit days for an episode during an LOS that exceeds the SSO threshold for an MS-LTC-DRG.	The patient is not liable for any non-covered days. You will receive the full MS-LTC-DRG payment.	The MS-LTC-DRG SSO threshold is 25 days, and the patient's benefit days end on day 30. The patient's LOS is 35 days. He or she is not liable for days 31 through 35 (the short-stay policy does not apply). Because you will receive the full MS-LTC-DRG payment, the patient is not liable until the first day the stay qualifies as a high cost outlier.

Note: Medicare provides 90 covered benefit days for an episode of care under the inpatient hospital benefit. Each patient has an additional 60 lifetime reserve days. The patient may use these lifetime reserve days to cover additional non-covered days of an episode of care that exceeds 90 days.

Any changes to a SSO outlier payment made as a result of reconciliation of SSO payments do not retroactively affect a patient's lifetime reserve days or coverage status, benefits, and payments under Medigap or Medicaid.

High Cost Outlier

The high cost outlier is an adjustment to the applicable LTCH PPS payment rate (either the site neutral rate or the standard Federal rate) for LTCH stays with unusually high costs that exceed the typical cost for cases with a similar case-mix. It equals 80 percent of the difference between the estimated cost of the case and the outlier threshold, and it is made in addition to the applicable LTCH PPS payment rate. In the case of a standard Federal rate payment, it is made in addition to the full MS-LTC-DRG payment or the adjusted SSO amount for the case. To qualify for the high cost outlier payment, your estimated costs to treat the case must exceed the outlier threshold. Note that site neutral cases paid based on costs cannot qualify for the high cost outlier adjustment. The applicable outlier threshold is calculated as the applicable LTCH PPS payment for the case plus the applicable fixed-loss amount. Beginning in FY 2016, CMS sets two fixed-loss amounts: one for the site neutral payment rate and one for the standard Federal rate.

The high cost outlier adjustment:

- ❖ Strongly improves the accuracy of the LTCH PPS in determining patient and hospital resource costs

- ❖ Reduces your financial losses that could result from treating patients who require more costly care
- ❖ Limits your loss to the fixed-loss amount and the percentage of costs above the marginal cost factor
- ❖ Reduces the incentive to under-serve high cost patients

Upon receipt of a claim, the Medicare Administrative Contractor (MAC) determines high cost outlier payments using PRICER software and whether there are enough benefit days for each medically necessary day in the outlier period. If the patient has enough benefit days, the claim is processed as usual, and you do not need to take any other action. If the patient does not have enough benefit days, the claim is returned to you for correction, with the appropriate high cost outlier threshold amount indicated.

For SSO cases, the MAC determines the outlier threshold by adding the fixed-loss amount to the adjusted SSO payment for the MS-LTC-DRG (not the full MS-LTC-DRG payment). If the estimated cost of the SSO case exceeds the high cost outlier threshold, it also qualifies as a high cost outlier case.

High Cost Outlier Payments When the Patient's Benefits Exhaust During an LTCH Stay

The high cost outlier payment is made only for:

- ❖ Days that the patient has Medicare coverage (regular, coinsurance, or lifetime reserve days) for the portion of the stay beyond the high cost outlier threshold
- ❖ Covered costs associated with medically necessary days for which the patient has a benefit day available

Note: Medicare provides 90 covered benefit days for an episode of care under the inpatient hospital benefit. Each patient has an additional 60 lifetime reserve days. The patient may use these lifetime reserve days to cover additional non-covered days of an episode of care that exceeds 90 days.

These tables provide examples of high cost outlier payments for patients whose benefits exhaust.



When Patient's Benefits Exhaust Before Qualifying for Full LTCH PPS Standard Federal Rate Payment

This scenario applies only to LTCH PPS standard Federal rate cases because under the site neutral payment rate calculation, a site neutral patient's benefits cannot exhaust before qualifying for full site neutral rate payment.

IF...	THEN...	EXAMPLE
<p>The patient's benefits exhaust before qualifying for the full MS-LTC-DRG payment, and the cost of covered care exceeds the standard Federal rate high cost outlier threshold for the applicable adjusted SSO payment.</p>	<p>You receive a high cost outlier payment in addition to the SSO adjusted payment for the covered medically necessary benefit days.</p>	<p>You admit a standard Federal rate patient with 5 remaining benefit days, and he or she is grouped to an MS-LTC-DRG with an ALOS of 30 days. The patient does not have enough regular benefit days to trigger the full MS-LTC-DRG standard Federal rate payment (5/6 of the ALOS for the MS-LTC-DRG) for this stay, which qualifies the case for an SSO adjusted payment. Your cost for providing covered services during the 5 benefit days exceeds the standard Federal rate high cost outlier threshold. The case also qualifies for a high cost outlier payment for all costs above the high cost outlier threshold for days 1 through 5. The patient is liable for day 6 through discharge.</p>

When Patient’s Benefits Exhaust After Qualifying for Full Applicable LTCH PPS Payment

“Full applicable LTCH PPS payment” refers to the standard Federal rate (including any SSO adjustment, if applicable) or the site neutral payment rate, as appropriate based on the LTCH case. “Applicable high cost outlier threshold” refers to the high cost outlier threshold determined from either the standard Federal rate fixed-loss amount or the site neutral fixed-loss amount, as appropriate based on the LTCH case.

IF...	THEN...	EXAMPLE
The patient’s benefits exhaust after qualifying for the full applicable LTCH PPS payment, and the cost of covered care exceeds the applicable high cost outlier threshold.	You will receive a high cost outlier payment in addition to the full LTCH PPS payment for the covered medically necessary benefit days.	You admit a standard Federal rate patient with 36 remaining benefit days, and he or she is grouped to an MS-LTC-DRG with an ALOS of 30 days. By day 33, the patient’s cost of care has exceeded the standard Federal rate high cost outlier threshold, which qualifies the case for both the full MS-LTC-DRG standard Federal rate payment and a high cost outlier payment for all covered costs (for which there are benefit days available) above the high cost outlier threshold. The patient is liable for day 37 through discharge.

When Patient’s Benefits Exhaust Before Exceeding the Applicable High Cost Outlier Threshold

“Full applicable LTCH PPS payment” refers to the standard Federal rate (including any SSO adjustment, if applicable) or the site neutral payment rate, as appropriate based on the LTCH case. “Applicable high cost outlier threshold” refers to the high cost outlier threshold determined from either the standard Federal rate fixed-loss amount or the site neutral fixed-loss amount, as appropriate based on the LTCH case.

IF...	THEN...	EXAMPLE
The patient qualifies for the full applicable LTCH PPS payment and uses all regular benefit days for a stay before exceeding the high cost outlier threshold.	You receive only the full applicable LTCH PPS payment (you will not receive a high cost outlier payment). The patient is not liable for costs incurred until the day after the applicable high cost outlier threshold for the case is exceeded.	You admit a standard Federal rate patient with 36 remaining benefit days, and he or she is grouped to an MS-LTC-DRG with an ALOS of 30 days. The patient’s cost of care does not exceed the standard Federal rate high cost outlier threshold until day 45. Because the patient exhausted all benefit days before reaching the high cost outlier threshold, the case is not eligible for a high cost outlier payment. The patient is not liable for covered costs from days 37 through 45. He or she is liable for day 46 through discharge.

If the patient’s benefits exhaust during the LTCH stay, you should determine:

- 1) The day of the stay in which the cost of the case reaches the applicable high cost outlier threshold (use charges per day and the CCR)
- 2) The number of benefit days the patient has available

To calculate the high cost outlier, use only the costs for the days after the cost of the case reaches the applicable high cost outlier threshold amount for which the patient has benefit days available. If the patient remains under care after benefits exhaust, the patient is liable for the costs of those remaining days.

Any changes to high cost outlier payments made under the LTCH PPS outlier policy do not retroactively affect a patient's lifetime reserve days or coverage status, benefits, and payments under Medigap or Medicaid.

Fixed-Loss Amounts

Beginning October 1, 2015, under the new dual-rate LTCH PPS payment structure, CMS sets two fixed-loss amounts: one for standard Federal rate payments and one for site neutral rate payments. The fixed-loss amount for cases paid based on the Federal rate is set at an amount that allows the projected total high cost outlier payments in a given year to equal 8 percent of the total LTCH PPS standard Federal rate payments estimated for that year (the full MS-LTC-DRG payments or the adjusted SSO amount plus high cost outlier payments). For FY 2017, the fixed-loss amount for site neutral cases is set at the same value as the IPPS fixed-loss amount.

The cost of each case is estimated using CCRs from the Provider Specific File (PSF). For those LTCHs for which CCRs in the PSF are unavailable, the applicable statewide average CCR is used. The MAC estimates the cost of a case by multiplying Medicare-covered charges for the case by the LTCH's overall CCR, which is calculated from the most recently settled or tentatively settled cost report. These CCR revisions or determinations may also apply:

- ❖ MACs may use an alternate CCR, as directed by CMS, which more accurately reflects recent substantial increases or decreases in a hospital's charges

- ❖ Upon approval by the respective CMS Regional Office (RO), LTCHs may request, based on substantial evidence, that MACs use a higher or lower CCR
- ❖ On an annual basis, MACs assign the statewide average CCR to LTCHs with CCRs above the maximum ceiling
- ❖ MACs do not assign the statewide average CCR for LTCHs with CCRs below the minimum floor; rather, the LTCH's actual CCR is used
- ❖ MACs may use the statewide average CCR when the LTCH CCR is undetermined (such as when a new LTCH has not submitted its first Medicare cost report or when data is not available to calculate a CCR due to being missing or faulty)

The LTCH PPS outlier policy allows for reconciliation of high cost outlier (and SSO) payments at cost report settlement and accounts for differences between the estimated CCR and the actual CCR for the period during which the discharge occurs.

Interrupted Stay

An interrupted stay occurs when a patient discharges from an LTCH and, after a specific number of days, readmits to the same LTCH for further medical treatment. For example, an LTCH patient may be discharged for treatment and services that are not available in the LTCH. Each stay is evaluated separately to make certain that it meets the interrupted stay criteria. A case may have multiple interrupted stays. A case with interrupted stays may be eligible for other case-level adjustments (such as the high cost outlier payment).

The two types of interrupted stays are 3-day or less interruption of stay and greater than 3-day interruption of stay.

1) Three-Day or Less Interruption of Stay

For discharges and readmissions to the same LTCH within 3 days, the patient may:

- ❖ Receive outpatient or inpatient tests, treatment, or care at an inpatient acute care hospital, Inpatient Rehabilitation Facility (IRF), or Skilled Nursing Facility (SNF)/Swing Bed
- ❖ Have an intervening patient stay at home for up to 3 days without the delivery of additional tests, treatment, or care

Any test, procedure, or care provided to an LTCH patient on an outpatient basis and any inpatient treatment during the interruption is the responsibility of the LTCH under arrangements, which means that such care (including inpatient surgical care at an inpatient acute care hospital) are part of that single episode of LTCH care and bundled into your payment. You must pay any other providers without additional Medicare Program payment liability. If the patient receives any tests or procedures any time during the 3-day interruption and you make payment to the intervening provider under arrangements, the total day count for the patient includes all days of the interruption. If the patient does not receive any care during the 3-day interruption, the total day count for the patient stay does not include the days away from the LTCH.

If a patient discharges to home and returns to the LTCH within 3 days without getting additional medical treatment, the days away from the LTCH are not included in the total LOS; however, if he or she receives treatment on any of the 3 days (for which you are responsible for under arrangements), the days must be counted in the total LOS.

2) Greater than 3-Day Interruption of Stay

If you discharge a patient to an inpatient acute care hospital, IRF, or SNF/Swing Bed and then readmit the patient after 3 days, these fixed-day periods apply:

- ❖ Inpatient acute care hospital – Between 4 and 9 days
- ❖ IRF – Between 4 and 27 days
- ❖ SNF/Swing Bed – Between 4 and 45 days

To meet the full definition of a greater than 3-day interruption of stay, the patient must also be discharged:

- ❖ Directly from the LTCH and admitted directly to an inpatient acute care hospital, IRF, or SNF/Swing Bed
- ❖ Back to the original LTCH after an LOS that falls within the applicable fixed-day period

The interrupted stay day count begins on the day of discharge from the LTCH and continues until the 9th, 27th, or 45th day after discharge (depending on the facility type). Although the greater than 3-day interruption of stay policy governs from the 4th day forward, the day count of the interruption begins on the first day the patient is away from the LTCH. For example, if a patient leaves the LTCH on Monday and returns during the same week on Wednesday, Wednesday is considered day 3.

If the applicable interrupted stay criteria are met, the days prior to the original discharge from the LTCH are added to the number of days following the readmission at the receiving facility. The days before and after an interrupted stay determine the total LOS for the episode of care.



If the patient is discharged to home, the greater than 3-day interruption of stay adjustment will not apply. If, however, the patient is discharged to home for 3 days or less, the 3-day or less interruption of stay adjustment applies as described above. If the patient's stay at an inpatient acute care hospital, IRF, or SNF/Swing Bed falls respectively within the fixed-day period, when the patient is readmitted to the LTCH, the entire stay is considered an interrupted stay. You will receive one payment (either a full MS-LTC-DRG payment or an adjusted SSO payment, as applicable) based on the initial admission. (The payment for an interrupted stay is eligible for a high cost outlier payment, as applicable.) The inpatient acute care hospital, IRF, or SNF/Swing Bed receives a separate payment if the greater than 3-day interruption of stay policy governs the patient stay. If the interruption in the LTCH stay exceeds the fixed-day period, the readmission to the LTCH is treated as a separate LTCH stay, and you will be paid an additional payment when the patient is discharged.

If the applicable interrupted stay criteria are met, you should not change the principal diagnosis when the patient returns to the LTCH from the receiving facility. If other medical conditions are apparent on the patient's return, you should note the additional diagnosis codes on the claim.

Payment Updates

For more information about LTCH PPS payment updates, refer to [Hospital Inpatient Prospective Payment System \(IPPS\) and Long Term Acute Care Hospital \(LTCH\) Final Rule Policy and Payment Changes for Fiscal Year \(FY\) 2017](#) and [FY 2017 IPPS/LTCH PPS Final Rule](#).

LTCH QRP

Section 3004(a) of the Affordable Care Act requires the establishment of the LTCH QRP. Beginning in FY 2014, LTCHs that do not report the quality data will be subject to a 2.0 percentage point reduction to the annual update of the standard Federal rate.

This table provides the quality reporting measures for the FY 2014 and FY 2015 annual update.

Measures Required for FY 2014 and 2015 Annual Update

Number	Required Measure
1	National Quality Forum (NQF) #0138—National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
2	NQF #0139—National Health Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure
3	NQF #0678—Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)

This table provides the quality reporting measures for the FY 2016 annual update.

Measures Required for FY 2016 Annual Update

Number	Required Measure
1	NQF #0138—National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
2	NQF #0139—National Health Safety Network (NHSN) Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure
3	NQF #0678—Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)
4	NQF #0680—Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Influenza Vaccine (Short Stay)
5	NQF #0431—Influenza Vaccination Coverage Among Healthcare Personnel

This table provides the quality reporting measures for the FY 2017 annual update.

Measures Required for FY 2017 Annual Update

Number	Required Measure
1	NQF #1716—National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure
2	NQF #1717—National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure

This table provides the quality reporting measures for the FY 2018 annual update.

Measures Required for FY 2018 Annual Update

Number	Required Measure
1	NQF #2512—All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals
2	NQF #0674—Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
3	NQF #2631—Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
4	NQF #2632—Functional Status Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support
5	National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure
6	NQF #2512—All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCHs

This table provides the quality reporting measure for the FY 2020 annual update.

Measures Required for FY 2020 Annual Update

Number	Required Measure
1	Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care

Resources

This table provides resources for the LTCH PPS.

Long Term Care Hospital Prospective Payment System Resources

For More Information About...	Resource
Long Term Care Hospital Prospective Payment System	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCare/HospitalPPS Chapter 3, Section 150, of the Medicare Claims Processing Manual (Publication 100-04)
Long Term Care Hospital Prospective Payment System Questions	ltchpps@cms.hhs.gov
Long Term Care Hospital Quality Reporting Program	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting Long Term Care Hospital (LTCH) Quality Reporting Program Reminders
Code of Federal Regulations	GPO.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule Policy and Payment Changes for Fiscal Year (FY) 2017	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-02.html
FY 2017 IPPS/LTCH PPS Final Rule	https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf
Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Long Term Care Hospital (LTCH) Quality Reporting Program Reminders	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1302.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf



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