Overview
This guide includes an overview of Medicare reimbursement methodologies and potential coding options for the use of select Medtronic technologies and services and related CY 2016 Medicare payment rates. Similarly, reimbursement opportunities may exist under individual state Medicaid programs and commercial payer policies. Providers should consult with their appropriate payer contacts to ensure alignment on coverage, coding, and payment expectations for the utilization of these technologies and/or the associated services.

Long Term Care Hospitals are defined by Medicare as having an average inpatient length of stay of greater than 25 days, and can be identified by the last four digits of their assigned provider number, ending with the last four digits of 2000-2299. These facilities typically furnish extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions.

Patient Benefits
LTCHs are certified as short-term acute care hospitals and as such are covered under a patient’s Medicare benefits for hospital insurance (Part A). This is different from actual long-term (or nursing home) care, for which coverage is only available when purchased separately as a supplemental healthcare plan. All services and supplies provided in a LTCH are covered with the exception of blood clotting factors, certain anesthesia services, and other administrative services.

Coverage
Medical Necessity: As in all cases with services and products provided to Medicare patients, all supplies and equipment which are ordinarily furnished by the hospital for the care and treatment of a patient during the LTCH stay are considered covered services, even if the supplies or equipment leave with the patient when discharged. For example, Medtronic tracheotomy tubes installed during the patient’s admission are covered under their Part A benefits and not separately billable.

Coding
Coding for LTCHs are reported under the ICD-10-CM and ICD-10-PCS systems. Payment to the hospital is determined by the patient’s principal diagnosis, up to eight additional diagnoses and up to six procedures performed during the stay. Providers may request coding assistance through the Medtronic Reimbursement Support Line at 877-278-7482.

Payment
LTCHs are certified as short-term acute care hospitals that are excluded from the Medicare Inpatient Prospective Payment System (IPPS). They are paid under Medicare’s LTCH Prospective Payment System (LTCH PPS) and must meet the individual state licensure requirements for acute care hospitals. Examples of facilities that are not subject to the LTCH PPS include veterans’ hospitals, foreign hospitals, and some facilities that are paid in accordance with demonstration projects.
The Centers for Medicare and Medicaid Services (CMS) established the LTCH PPS in 2003, which is directly based on the previously mentioned IPPS Medicare Severity Diagnosis Related Groups (MS-DRGs). The LTCH PPS annual cycle begins each year. The rates are updated July 1 and run through June 30 annually to reflect the changes in new technology, treatment patterns, and other influences that may change the use of hospital resources.

The Pathway for SGR Reform Act of 2013 provided for the establishment of site neutral payment rate criteria under the LTCH PPS, with implementation beginning FY 2016. As a result CMS has established two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria: the LTCH PPS standard federal payment rate and a new LTCH PPS site neutral payment rate comparable to the IPPS payment rates.

Under the LTCH PPS standard federal payment methodology, CMS uses the IPPS MS-DRGs and assigns different relative weight values based on a geometric average length of stay to establish the Medicare Severity Long Term Care Diagnosis Related Group (MS-LTC-DRG) payment rates. Medicare reimburses LTCHs a single MS-LTC-DRG for a patient’s entire admission as determined by their principal and additional diagnoses and procedures performed during the stay, along with their age, sex, and final discharge status. The actual payment rate is calculated using a formula based on the relative weight of the MS-LTC-DRG multiplied by the Standard Federal Rate. Other facility-level and case level adjustments may also made. The Standard Federal Rate for FY 2016 is $40,941.55.

Alternatively, if a patient meets the following criteria, the LTCH will be paid under the new site neutral payment rates:

1. The discharge from the LTCH does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation
2. Admission to the LTCH was immediately preceded by discharge from a subsection (d) hospital if there was a direct admission from such a hospital, as evidenced by the dates of discharge and admission
3. The immediately preceding stay in a subsection (d) hospital included at least 3 days in an intensive care unit (ICU) or the discharge from the LTCH is assigned to a MS-LTC-DRG based on the patient’s receipt of ventilator services of at least 96 hour as indicated by the use of ICD-10-PCS procedure code 5A1955Z

The site neutral payment rate for CY 2016 is the lesser of the IPPS comparable per diem amount (including any outlier payments), or 100% of the estimated cost of the case. For discharges occurring in cost reporting periods beginning during FY 2016 and FY 2017, the payment amount for site neutral payment rate cases will be a blended payment rate. This blended rate will be calculated as 50% of the applicable site neutral payment rate amount for the discharge, and 50% of the applicable LTCH PPS Standard Federal Payment rate.

Patients admitted to these facilities typically have an average length of stay greater than 25 days. However, changes to the lengths of stay may affect payment and individual case level adjustments may apply.

- **Short-Stay Outliers** (does not apply to site neutral payments), when a patient has a length of stay between one day and up to and including 5/6 of the MS-LTC-DRG average length of stay, the facility is paid the lowest of:
  - 120% of the cost of the case; or
  - 120% of the MS-LTC-DRG specific per diem amount; or
  - The full MS-LTC-DRG payment

- **Interrupted Stays:** Adjusted payments are also made when a patient is discharged from the LTCH and immediately admitted to an inpatient acute care hospital, an inpatient rehabilitation facility or a Skilled Nursing Facility (SNF) swing bed and returns to the same LTCH within a specified period of time. If the following times are realized, the stay is recognized as a single discharge with one payment.
  - ≤9 days in an inpatient acute care hospital
  - ≤27 days in an inpatient rehabilitation facility
  - ≤45 days in a SNF swing bed and return to the same LTCH

- **High Cost Outliers:** Additional payment is made to an LTCH when their costs have exceeded the outlier threshold for an individual patient’s stay. If that occurs, the facility is reimbursed the MS-LTC-DRG payment plus a fixed-loss amount equal to 80% of the costs above the outlier threshold, or the site neutral payment rate case equal to the IPPS. Costs are determined by Medicare using the charges from the claims and the hospital’s specific cost-to-charge ratio (CCR).
Additional Payment Under Part B

Providers furnishing care to a patient in an LTCH should bill their services separately under Part B to the Medicare Administrative Contractor (MAC). This includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, qualified psychologists, and anesthetists.

Any durable medical equipment (DME) and supplies used during LTCH covered stay are included in the payment to that facility and not separately billable. Subsequently, any DME and supplies furnished to a patient for use only outside the facility should be billed under the patient’s Part B benefits. For Medtronic products, this may include ventilator accessories, enteral nutrition supplies, and remote monitoring devices.

Quality Reporting

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) imposed new data reporting requirements for certain post-acute care providers, including LTCHs. This includes submission of standardized data using assessments for use in the quality measures for which the IMPACT Act specifies five domains. LTCHs must submit the required data or risk a 2% point reduction in their annual payment update. Included in the measures are an All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from LTCH (NQF #2512) which will affect payment in FY2017. This will measure unplanned, all-cause readmissions discharged from a LTCH who are readmitted to a short-term acute care hospital or LTCH within 30 days of discharge from a LTCH.

You can find details about the LTCH quality reporting measures, data submission deadlines and reconsiderations, exceptions, and extensions at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html#downloads

Therapy Specific Coding and Reimbursement Information

All supplies and equipment which are ordinarily furnished by the hospital for the care and treatment of a Medicare patient during the LTCH stay are considered covered services under Part A, even if the supplies or equipment leaves with the patient when discharged. This includes the following Medtronic products:

- Enteral feeding, access and GI products
- Compression systems and sleeves
- Electrodes for monitoring and diagnostics
- Incontinence products
- Oximetry products
- Sharps safety products
- Tracheostomy supplies
- Urology catheters
- Ventilators
- Wound care dressings

Any of the above durable medical equipment (DME) and supplies used during LTCH covered stay are included in the payment to that facility and not separately billable. Subsequently, any DME and supplies furnished to a patient for use only outside the facility should be billed under the patient’s Part B benefits. Please refer to the Medtronic Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Reimbursement Reference Guide.
REFERENCES:
1 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates Final Rule, Federal Register (80 Fed Reg, No. 158). August 17, 2015, 42 CFR Part 412).

DISCLAIMER:
The information contained in this guide is for educational purposes only and is not intended to serve as reimbursement advice. The information herein is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information is subject to change, cannot guarantee coverage or reimbursement. Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient’s condition and procedures performed for a patient and to consult with each patient’s health plan for appropriate reporting of each procedure. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, CPT, ICD-10, Revenue Code publications, or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.

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