CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2083	**Date: October 29, 2010**
	Change Request 7044

Transmittal 2009 dated July 29, 2010, is rescinded and replaced by Transmittal 2083, dated October 29, 2010, to add business requirement 7044.7.2, and modify 7044.1, 7044.7.1, 7044.8, 7044.8.1, 7044.9, 7044.9.1, and 7044.10 to update the provider range, update the Remittance Advice Remark Code and to include references to new Pricer Return code '04'. The Effective and Implementation dates have not been changed. All other information remains the same.

SUBJECT: Implementation of the Interrupted Stay Policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. SUMMARY OF CHANGES: The Office of Inspector General drafted a report entitled: ?Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007, (A-01-09-00508). Based on findings in this report, CMS is implementing the interrupted stay policy where the patient is admitted to another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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
R	3/190.7.1 - Interrupted Stays
R	3/190.16 - IPF PPS System Edits
R	3/190.17.1 - Inputs/Outputs to PRICER

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2083	Date: October 29, 2010	Change Request: 7044

Transmittal 2009 dated July 29, 2010, is rescinded and replaced by Transmittal 2083, dated October 29, 2010, to add business requirement 7044.7.2, and modify 7044.1, 7044.7.1, 7044.8, 7044.8.1, 7044.9, 7044.9.1, and 7044.10 to update the provider range, update the Remittance Advice Remark Code and to include references to new Pricer Return code '04'. The Effective and Implementation dates have not been changed. All other information remains the same.

SUBJECT: **Implementation of the Interrupted Stay Policy under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)**

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: January 3, 2011

I. GENERAL INFORMATION

A. Background: Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented January 2005. One aspect of the IPF PPS included an interrupted stay policy.

On May 5, 2010, the Office of Inspector General drafted a report entitled: "Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007," (A-01-09-00508). Based on findings in this report, CMS is implementing the interrupted stay policy where the patient is admitted to another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

B. Policy: An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay. Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment whether the interrupted stay is to the same IPF or not. For an interrupted stay to the same IPF, interrupted stays are considered to be continuous for determining if the case qualifies for an outlier payment.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7044.1	CWF shall create an edit to identify claims that qualify as interrupted stays to another IPF by examining an incoming IPF claim against history IPF claims. An interrupted stay to another IPF is a case in which a patient is discharged from an IPF and is readmitted to another IPF before midnight on the third consecutive day									X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	following discharge from the original IPF stay. Note: IPF claims are identified by a Type of Bill 11X with one of the following provider numbers: xx4000 - xx4499, xxSxxx, or xxMxxx.										
7044.1.1	CWF shall identify all history claims that would be impacted by this policy (see attachment for scenarios).									X	
7044.1.2	When an interrupted stay is identified under IPF, CWF shall appropriately sum the covered days from the history claim(s).									X	
7044.1.3	CWF shall pass the sum of covered days back to FISS in the CWF response.									X	
7044.2	Upon receiving the CWF response, FISS shall append payer-only value code 75 (Prior covered days for interrupted stay) to the claim.						X				
7044.2.1	FISS shall accept value code 75 in the same format as value code 80.						X				
7044.2.2	FISS shall set the value for value code 75 to the amount reported on the CWF response representing the total covered days.						X				
7044.3	FISS and the IPF PPS Pricer shall create a new 3-byte, numeric field entitled, 'PRIOR-DAYS-BILL'.						X				IPF Pricer
7044.3.1	FISS shall set the 'PRIOR-DAYS-BILL' to a zero.						X				
7044.3.2	FISS shall send the 'PRIOR-DAYS-BILL' to the IPF PPS Pricer.						X				
7044.4	FISS shall transfer the number of covered days in value code 75 (if present) to the new 'PRIOR-DAYS-BILL' field.						X				
7044.5	FISS shall recycle IPF claims with value code 75 through the IPF PPS Pricer.						X				
7044.6	FISS shall prevent providers from entering/editing this payer-only value code 75.						X				
7044.7	The IPF PPS Pricer shall use the 'PRIOR-DAYS-BILL' to correctly apply the variable per diem adjustment factor (i.e., to essentially begin with the next variable per diem adjustment factor that the prior IPF stay left off at).										IPF Pricer
7044.7.1	The IPF PPS Pricer shall create a new return code, 03 = Paid Standard IPF payment with variable per diem adjustment based on covered days from prior stay (interrupted stay), to identify claims where the 'PRIOR-DAYS-BILL' amount was greater than zero.										IPF Pricer
7044.7.2	The IPF PPS Pricer shall create a new return code, 04 =										IPF

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	Paid as a Cost Outlier with variable per diem adjustment based on covered days from prior stay (interrupted stay), to identify claims where the 'PRIOR-DAYS-BILL' amount was greater than zero.										Pricer
7044.8	FISS shall accept the new IPF PPS Pricer return codes, 03 and 04.						X				
7044.8.1	To prevent a continuous looping of a claim between CWF and FISS, CWF shall not send a response to FISS (as instructed in requirements 1.1, 1.2 and 1.3 above) when receiving an IPF claim that has the IPF PPS Pricer return code, 03 or 04, unless the sum of covered days changes the amount for value code 75.									X	
7044.9	FISS shall use the IPF PPS Pricer return code, 03 or 04, to identify claims that received a reduction in payment due to the variable per diem adjustment being applied from an IPF interrupted stay.						X				
7044.9.1	Contractors shall use the following messages to communicate to providers that a reduction in payment occurred due to the variable per diem adjustment being applied from an IPF interrupted stay: <u>Claim Adjustment Reason Code:</u> 45- Contractual Adjustment. <u>Remittance Advice Remark Code:</u> N540 - Payment adjusted based on the interrupted stay policy. Note: The above RARC message is currently being requested. Once received/approved, this CR will be re-issued with the finalized message. <u>Contractual Obligation:</u> CO – Contractual Obligation	X		X							
7044.10	CWF shall send an unsolicited response, on all impacted claims, to contractors to reprocess the history IPF claim(s) when the Pricer return code '03' or '04' is not present on the incoming claim or history claim(s). Note: IPF claims that qualify as an interrupted stay need to be processed in date of service sequence to apply an accurate variable per diem adjustment.									X	
7044.10.1	When receiving the unsolicited response, contractors shall	X		X			X				

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	reprocess affected claim(s).										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7044.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

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):
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Sarah Shirey-Losso at sarah.shirey@cms.hhs.gov or 410-786-0187
Fred Rooke at fred.rooke@cms.hhs.gov or 410-786-6987
Jason Kerr at jason.kerr@cms.hhs.gov or 410-786-2123

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

Attachment

ATTACHMENT

IPF PPS Interrupted Stay Claim Examples

Assumptions:

1. CWF tracking begins with IPF claims with Dates of Service (DOS) on or after January 1, 2011
2. Each claim is a discharge claim from another IPF (Note: Year is not indicated with DOS but assume its 2011)

Claim	DOS	Covered Days	Interrupted Stay	CWF Action	FISS Action	Pricer
1	1/1-1/10	9	No	Track total covered days column	None	Pay Day 1-9 per diem
2	1/12-1/20	8	Yes	Send trailer to FISS w/ 9 total covered days from claim 1	Assign payer only value code 75 w/ 9 days	Apply per diem adjustment from day 10 (first 9 days already applied on prior claim)
3	1/22-1/24	2	Yes	Send trailer to FISS w/ 17 total covered days (from claim 1 and 2 above because they are both continuing interrupted stays)	Assign payer only value code 75 w/ 17 days	Apply per diem adjustment from day 18
4	1/29-1/31	2	No	No action, claim admit date is not within 3 days of prior claims' discharge date.	No action	Apply per diem adjustment from day 1 (no interrupted stay)

Initiating Unsolicited responses

Below are claims 3 and 4 from above, and a new claim that comes in out of sequence that ultimately links claims 3 and 4

Claim	DOS	Covered Days	Interrupted Stay	CWF Action	FISS Action	Pricer
3	1/22-1/24	2	Yes	Send trailer to FISS w/ 17 total covered days (from claim 1 and 2 above because they are both continuing interrupted stays)	Assign payer only value code 75 w/ 17 days	Apply per diem adjustment from day 18
X	***1/25-1/27***	***2***	***Yes***	***Send trailer to FISS w/ 19 total covered days (from claims 1-3)***	***Assign payer only value code 75 w/ 19 days***	***Apply per diem adjustment from day 20***
4	1/29 - 1/31	2	Yes	CWF does unsolicited on this claim and now sends trailer to FISS w/ 21 total covered days	Assign payer only value code 75 w/ 21 days	Apply per diem adjustment from day 22

Notes:

1. When claim X comes into the claims processing system out of sequence, claims 3 and 4 are linked into interrupted stay because of the out of sequence claim X.

2. Therefore, CWF needs to do an unsolicited on Claim 4 (which now becomes claim 5) because there is no longer a break in interrupted stays. CWF would then send the tally of covered days in a trailer to CWF.

3. This new process is similar to existing spell processing performed in the claims processing system.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

190.7.1 - Interrupted Stays
(Rev. 2083, Issued: 10-29-10, Effective: 01-01-11, Implementation: 01-03-11)

An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

*For a patient who is discharged and readmitted to the same IPF, i*nterrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for an outlier payment. In other words, an interrupted stay is treated as one stay and one discharge for the purpose of payment. Thus, the IPF should hold the claim for 3 days to ensure there is not a readmission that soon. In this way, the readmission is included on the original claim.

For example, if a patient leaves the IPF on 1/1 and returns to the same IPF on 1/3, this is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills are allowed.

For a patient who is discharged and readmitted to another IPF, interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment.

For example, if a patient is discharged from IPF "A" and within 3 days is readmitted to IPF "B," *this is considered an interrupted stay under IPF PPS. There will be no provider action. FISS will process the claim from IPF "B" with information received from CWF on covered days from the claim received from IPF "A"(this information will be displayed in FISS with a value code 75 on claim that is processed for IPF "B").*

Medicare contractors should monitor trends to ensure IPFs are not consistently admitting, discharging, and readmitting patients in order to receive the larger variable per diem payments associated with the first days of a patient's stay.

190.16 - IPF PPS System Edits
(Rev. 2083, Issued: 10-29-10, Effective: 01-01-11, Implementation: 01-03-11)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines, and

- the length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

FISS shall ensure that Value Code 75 is allowed from contractor entry and not allowed from Provider entry. Also, Providers are not allowed to alter this information.

CWF shall ensure that Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the *same* IPF within 3 days).

CWF shall ensure that Value Code 75 is present on claims when there is an interrupted stay resulting from a discharge at another IPF (the beneficiary has been admitted, within 3 days, to an IPF that is a different IPF from which he/she had been previously discharged).

190.17.1 - Inputs/Outputs to PRICER

(Rev. 2083, Issued: 10-29-10, Effective: 01-01-11, Implementation: 01-03-11)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator
9	Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.
12	Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)
17	Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)
18	Federal PPS Blend Indicator (must be 1, 2, 3, or 4)
21	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same

	methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)
22	Cost of Living Adjustment (COLA)
23	Intern/Bed Ratio
25	Combined Capital and Operating Cost to Charge Ratio
33	Special Wage Indicator (should be set to 1 if there is a change to the wage index.)
35	Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)
38	Special Wage Index
48	New Hospital

Bill Data

National Provider Identifier	Covered Charges
OSCAR Number	Discharge Date (or benefits exhaust date if present)
Patient Age	Other Diagnosis Codes
DRG	Other Procedure Codes
Length of Stay	Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.
Source of Admission	ECT Units
Patient Status Code	Claim Number
	Indicator for Value Code75 to apply variable per diem adjustment to this bill.

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment
DRG/MS-DRG Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
Per Diem Adjusted Payment
Facility Adjusted Payment
Age Adjusted Payment
Rural Adjusted Payment
Teaching Adjusted Payment
ED Adjusted Payment
ECT Adjusted Payment

National Non-Labor Rate
Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate
Standardized Factor
Labor Share
Non-Labor Share
COLA
Day of Stay Adjustment
Age Adjustment
Comorbidity Adjustment

Return Code
MSA/CBSA
Wage Index
National Labor Rate
DRG Adjustment
Rural Adjustment
ECT Adjustment
Blend Year Calculation Version