

c. Interrupted Stay

In § 412.531(a), we define an "interruption of a stay" as a stay at a LTCH during which a Medicare inpatient is admitted upon discharge from the LTCH to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed day periods. For a discharge to an acute care hospital, the applicable fixed-day period is 9 days. For a discharge to an IRF, the applicable fixed-day period is 27 days. For a discharge to a SNF, the applicable fixed-day period is 45 days. The counting of the days begins on the day of discharge from the LTCH and ends on the 9th, 27th, or 45th day for an acute care hospital, an IRF, or a SNF, respectively. (We refer readers to section VII.C.4.e. of this preamble for a discussion of application of this interrupted stay policy to Medicare-participating providers with approved swing beds.)

If the patient's length of stay away from the LTCH does not exceed the fixed-day thresholds, the return to the LTCH is considered part of the first admission and only a single LTCH PPS payment will be made. (From the standpoint of implementing this policy, in the event that a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider should cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. For further details, see Program Memorandum Transmittal A-02-093, September 2002.) On the other hand, if the patient stay exceeds the total fixed-day threshold outside of the LTCH at another facility before being readmitted, two separate LTC-DRG payments will be made, one based on the principal diagnosis for the first admittance and the other based on the principal diagnosis for the second admittance. Moreover, if the principal diagnoses are the same for both admissions, the hospital could receive two similar payments. (See section VII.C.4.e. of this final rule for application of the interrupted stay policy to transfers to swing bed hospitals.)

d. Onsite Discharges and Readmittances

Under § 412.532, generally, if a LTCH readmits more than 5 percent of its Medicare patients who are discharged to an onsite SNF, IRF, or psychiatric facility, or to an onsite acute care hospital, only one LTC-DRG payment will be made to the LTCH for discharges and readmittances during the LTCH's cost reporting period. Therefore,

payment for the entire stay will be paid either as one full LTC-DRG payment or a short-stay outlier, depending on the duration of the entire LTCH stay.

In applying the 5-percent threshold, we apply one threshold for discharges and readmittances with a co-located acute care hospital. There is also a separate 5-percent threshold for all discharges and readmittances with co-located SNFs, IRFs, and psychiatric facilities. In the case of a LTCH that is co-located with an acute care hospital, an IRF, or a SNF, the interrupted stay policy at § 412.531 applies until the 5-percent threshold is reached. However, once the applicable threshold is reached, all such discharges and readmittances to the applicable site(s) for that cost reporting period are paid as one discharge. This means that even if a discharged LTCH Medicare patient was readmitted to the LTCH following a stay in an acute care hospital of greater than 9 days, if the facilities share a common location and the 5-percent threshold were exceeded, the subsequent discharge from the LTCH will not represent a separate hospitalization for payment purposes. Only one LTC-DRG payment will be made for all such discharges during a cost reporting period to the acute care hospital, regardless of the length of stay at the acute care hospital, that are followed by readmittances to the onsite LTCH.

Similarly, if the LTCH has exceeded its 5-percent threshold for all discharges to an onsite IRF, SNF, or psychiatric hospital or unit, with readmittances to the LTCH, the subsequent LTCH discharge for patients from any of those sites for the entire cost reporting period will not be treated as a separate discharge for Medicare payment purposes. (As under the interrupted stay policy, payment to an acute care hospital under the IPPS, to an IRF under the IRF PPS, and to a SNF under the SNF PPS, will not be affected. Payments to the psychiatric facility also will not be affected.)

e. Treatment of Swing Beds Under the Interrupted Stay and Onsite Discharge and Readmittance Policies

A swing-bed hospital is defined at § 413.114(b) as a hospital or critical access hospital (CAH) participating in Medicare that has an approval from CMS to provide post-hospital SNF care as defined in § 409.20 and meets the requirements specified in § 482.66 or § 485.645. Swing beds are otherwise licensed hospital beds that may, under certain circumstances, be used temporarily as SNF beds. Under § 413.114(a)(2), post-hospital SNF care

furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the SNF PPS for services furnished for cost reporting periods beginning on or after July 1, 2002. Since it is possible for a Medicare beneficiary to be discharged from a LTCH for post-hospital SNF care that is being provided by another hospital-level Medicare provider with swing beds, such a discharge would be considered the same as if it were to an individual SNF. We interpret the extension of the SNF PPS to swing beds to require that all payment policy determinations regarding patient movement between LTCHs and SNFs, including the onsite policy described above, also apply to swing beds.

In the March 7, 2003, proposed rule (68 FR 11254), we stated that we want to emphasize that our inclusion of swing beds in payment policy determinations for all patient movement between LTCHs and SNFs (see section VII.C.4.c. of this preamble) would mean that a readmission to a LTCH from post-hospital SNF care being provided in a swing bed that is located either in the LTCH itself or in another onsite Medicare provider would have the same policy consequences as would a readmission to the LTCH from an onsite SNF. We received no comments on this clarification.

5. Other Payment Adjustments

As indicated earlier, we had broad authority under section 123 of Public Law 106-113, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs. Thus, in the August 30, 2002, final rule (67 FR 56014-56027), we discussed our extensive data analysis and rationale for not implementing an adjustment for geographic reclassification, rural location, treating a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. In that same final rule, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented. As we stated in the March 7, 2003, proposed rule (68 FR 11254), because the LTCH PPS was only recently implemented, sufficient new data have not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Therefore, in that same proposed rule, we did not propose an adjustment for geographic reclassification, rural location, DSH, or IME at this time. Additionally, we stated