



IPF PPS CONTRACTOR TRAINING GUIDE

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Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

PREPARED BY

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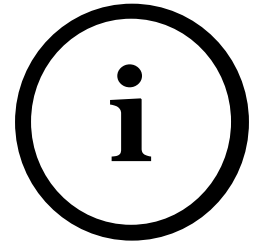
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Using This Training Guide

This training guide is divided into three chapters:

- ♦ **IPF PPS Overview**
- ♦ **Payment**
- ♦ **Billing**

Although each chapter builds upon the previous chapter, each is also comprehensive enough to use for focused training if used in conjunction with the IPF PPS Overview chapter. This guide has been designed to assist FIs and providers in the basic understanding of the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) program and implementation, including information on the IPF PPS components, important changes, and additional resources.

This guide will ease the reader through the IPF PPS using headings and icons to organize and highlight key concepts.

ICON KEY

 **Quick Fact**

 **Example**

 **Background**

Throughout the guide you will encounter icons that will assist learners in their pursuit of understanding, as well as aid you in quickly finding reference points in the future.

Acronyms

Commonly used acronyms in the IPF PPS Final Rule and their corresponding terms are outlined below.

ADC	Average Daily Census
BBA	Balanced Budget Act of 1997, Public Law 105-33
BBRA	Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106-113
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106-554
CY	Calendar Year
CAH	Critical Access Hospitals
CBSA	Core-Based Statistical Area
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of living adjustment
CWF	Common Working File
DRG	Diagnosis-related group
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition Text Revision is the most current version of the DSM.
ECT	Electroconvulsive Therapy
ED	Emergency Department
FR	Federal Register
FL	Form Locator

INTRODUCTION TO IPF PPS

FI	Fiscal Intermediary
FISS	Fiscal Intermediary Shared System
FY	Fiscal Year
FTE	Full Time Equivalent
GME	Graduate Medical Education
GROUPER	Software that determines the DRG from data elements reported by the IPF
HCPCS	Health Care Common Procedure Coding System
IME	Indirect Medical Education
IPPS	Inpatient (Acute Care Hospital) Prospective Payment System
IPF PPS	Inpatient Psychiatric Facility Prospective Payment System
ICD-9-CM	International Classification of Diseases - 9 th Revision – Clinical Modifications
LTCH	Long-term care hospital
MCE	Medicare Code Editor
MedPAR	Medicare Provider Analysis and Review file
MSA	Metropolitan Statistical Area
MCGRB	Medical Geographic Classification Review Board
OMB	Office of Management and Budget
OCE	Outpatient Code Editor
PIP	Periodic Interim Payment
PRICER	Pricing software
SNF	Skilled Nursing Facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248

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	97-248
UB-92	Uniform Billing Form, released in 1992 and implemented in 1994
VA	Veterans Administration

Definitions

Commonly used terms in the IPF PPS Final Rule and their corresponding terms have been defined below:

DRG	The diagnosis-related group used to classify a patient's discharge for payment purposes. IPF PPS includes 15 DRG adjustment factors that are classified by the same GROUPER software developed by 3M for the hospital inpatient PPS (Version 22 for FY 2005).
Etiology	The science dealing with the causes of disease.
Comorbidity	Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis, and that require treatment during the stay. They are determined by secondary ICD-9-CM diagnostic codes. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded.
IPF	Unless stated otherwise, both psychiatric hospitals, distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs) will be referred to in this training guide as IPFs.
ECT	Electroconvulsive Therapy (ECT) is a technique for treating psychiatric patients, in which seizures similar to those of epilepsy are induced by passing a current of electricity through the forehead.
Outlier	An additional payment made to an IPF for unusually costly cases to help it avoid substantial losses and to promote access to care for patients requiring expensive care.

IPF PPS Overview

Highlights of the IPF PPS

Objective

This section will introduce the new Medicare IPF PPS used for inpatient hospital services provided by an IPF to psychiatric patients to help IPFs and FIs gain high-level understanding of the entire IPF PPS before learning the details of the new initiative. In addition, it will give background information so that participants will understand why the new PPS was created.



OVERVIEW

Participants will learn the following information in the course of this chapter:

- Statutory basis for the IPF PPS
- IPFs impacted and not impacted
- Implementation guidelines for the transition
- Stop-loss provision
- Overview

Background

When the Medicare statute was originally enacted in 1965, Medicare payments for inpatient hospital services were based on the reasonable costs incurred in furnishing services to people with Medicare.

Statutory Basis

In 1972, Section 223 of the Social Security Act Amendments set forth limits on reasonable costs for inpatient hospital services (Pub. L. 92-603). A subsequent revision of the Medicare statute capped payments limiting allowable costs per discharge. (For more information, see section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248).)

In 1983, Congress replaced the reasonable cost-based payment system for inpatient services in acute care hospitals with an Inpatient Prospective Payment System (IPPS). This amendment to the Social Security Act covered most inpatient hospital services (Pub. L. 98-21, section 601, sec.1886 (d)). However, IPFs were excluded from the IPPS.

Congress later replaced the TEFRA with 3 PPS systems for these facilities excluded from the IPPS:

- Rehabilitation hospitals and rehabilitation units in acute care hospitals (IRFs)
- Long-term care hospitals (LTCHs)
- Psychiatric hospitals and psychiatric units in acute care hospitals (IPFs)

Section 124 of the BBRA mandated CMS to:

- Develop a per diem PPS for inpatient hospital services furnished in IPFs
- Include an adequate patient classification system that reflects the differences in patient resource use and costs among IPFs
- Maintain budget neutrality
- Require IPFs to submit information necessary for the development of the PPS
- Submit a report to Congress describing the PPS development



BACKGROUND

The changes were mandated in three separate Acts:

- ☑ The Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33)
 - ☑ The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act (BBRA) (Pub. L. 106-113)
 - ☑ The Centers for Medicare & Medicaid Services (CMS)-1213-F 7 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554)
-

INTRODUCTION TO IPF PPS

Section 124 of the BBRA also required that a PPS for IPFs be implemented for cost reporting periods beginning on or after October 1, 2002. However, implementation was delayed in order to conduct the necessary research, publish the proposed rule for comment, and publish the final rule after comments were received and analyzed.

CMS published the final rule on Nov. 15, 2004. Payments for IPF services delivered for cost reporting periods starting on or after January 1, 2005 will be based on the policies set forth in the final rule (69 FR 66922).

IPFs Affected by IPF PPS

The IPF PPS will affect IPFs, which include freestanding psychiatric hospitals, distinct part psychiatric units of general acute care hospitals, and distinct part psychiatric units of Critical Access Hospitals (CAHs) that provide psychiatric services to Medicare beneficiaries. MMA §405(g) indicated that certified psychiatric units in CAHs be paid under the IPF PPS.

IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals and of CAHs which have been excluded from the hospital inpatient PPS under §1886(d)((1)(B)(i) of the Social Security Act, and are included in IPF PPS for purpose of Medicare payment.

IPFs:

- Provide psychiatric services for the diagnosis and treatment of mentally ill patients by or under the supervision of a physician;
- Maintain clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient; and
- Meet staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution.

An IPF certified as a distinct part psychiatric unit must be certified and meet the clinical record and staffing requirements in §412.27 to be considered a “psychiatric hospital.”



QUICK FACTS

- ☑ Psychiatric hospitals and distinct part psychiatric units of acute care hospitals or CAHs are referenced in this training guide as IPFs.
 - ☑ IPF provider numbers range from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx
-

IPFs Not Affected by IPF PPS

The following facilities are excluded from the IPF PPS:

- Veterans Administration (VA) hospitals
- Hospitals reimbursed under state cost control systems approved under 42 Code of Federal Regulations (CFR) Part 403
- Hospitals reimbursed in accordance with demonstration projects authorized under §402(a) of Pub. L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub. L. 92-603 (42 U. S. C. 1395b-1)
- Non-participating hospitals furnishing emergency services to Medicare beneficiaries (See §412.22(c).)

Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation.

Maryland IPFs

Freestanding IPFs in Maryland will be paid under the IPF PPS; Maryland IPFs certified as distinct part units of an acute care hospital are waived from the IPF PPS (identified by 'S' in provider number). There are no CAHs in Maryland.

All other IPFs not paid in accordance with any of the exceptions mentioned above will be paid under the IPF PPS.

Implementation Phase-In

IPF PPS is effective for IPFs with cost reporting periods beginning on or after January 1, 2005 and this new PPS replaces the TEFRA payment methodology currently used to reimburse IPF providers. An IPF begins the new IPF PPS at the beginning of its new 2005 cost reporting period.

 **TRANSITION EXAMPLE**

For example, if an IPF's fiscal year ends on January 31, 2005, then IPF PPS billing and reimbursement rules begin for this IPF on February 1, 2005. This is also the beginning date of the IPF's first transition year.

If an IPF's cost reporting period ends on September 30, 2005, then IPF PPS billing and reimbursement rules begin for this IPF on October 1, 2005. This is also the beginning date for the IPF's first transition year.

There is a three-year transition period into the new IPF PPS whereby IPFs will receive a blended payment. The blended payment will consist of the federal per diem payment amount and the facility-specific payment amount which the IPF would have received under the TEFRA payment methodology. This approach strikes an appropriate balance between IPFs that are prepared to fully implement the IPF PPS immediately and those IPFs that need time to make changes before implementing the new payment system.

During each year of the transition period, IPF PPS payments will increase as a percentage of the total while the TEFRA payments decrease as a percentage of the total. Specifically:

- The first year of the transition is for cost reporting periods beginning on or after January 1, 2005 and prior to January 1, 2006. The cost-based TEFRA system will be used to calculate 75 percent of the total payment for this period. The IPF PPS will be used to calculate 25 percent of the total payment.
- The second year of the transition covers cost reporting periods beginning on or after January 1, 2006 and prior to January 1, 2007. The cost-based TEFRA system will be used to calculate 50 percent of the total payment for this period. The IPF PPS will be used to calculate 50 percent of the total payment.
- The third and final year of the transition will start for cost reporting periods beginning on or after January 1, 2007 and prior to January 1, 2008. The cost-based TEFRA system will be used to calculate 25 percent of the total payment for this period.

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The IPF PPS will be used to calculate 75 percent of the total payment.

- The first full year of PPS payment will start with cost reporting periods beginning on or after January 1, 2008. IPFs will be paid 100 percent of the PPS amount.

This chart illustrates the transition period:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

The purpose of the transition period is to provide time for currently existing IPFs to adjust to the new PPS payment and the effects caused by changing to the PPS.

Existing Providers

The transition period is mandatory. All existing IPFs will receive the blended TEFRA/PPS payments during the three-year transition period.

New Providers

New IPFs will be paid the full standardized Federal per diem payment amount rather than a blended payment amount because the transition period is intended to provide currently existing IPFs time to adjust to the new payment system.

A new IPF is defined as a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs, set forth in §412.22, §412.23, §412.25, and §412.27, which under current ownership, previous ownership, or both, that has not received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005. To qualify, the first cost report period as a psychiatric hospital or a distinct part unit in an acute care hospital must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.



QUICK FACT

Existing IPFs will not have the option to receive 100 percent of the IPF PPS payment amount during the transition period.

Overview

Payment Rate

Payments to IPFs under the IPF PPS will be based on a single standardized Federal per diem base rate. The standardized Federal per diem base rate is \$575.95.

The \$575.95 standardized Federal per diem base rate may be adjusted by facility-level and patient-level adjustments. This PPS payment will include reimbursement for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs:

- Bad debts
- Direct graduate medical education
- Nursing education programs
- Allied health

The pass through costs will be settled on the cost report.

Payment Adjustments

The \$575.95 standardized Federal per diem rate may receive these **patient-level adjustments**:

- A DRG adjustment
- A comorbidity adjustment;
- An age adjustment;
- A variable per diem adjustment; and
- An adjustment for each Electroconvulsive therapy (ECT) treatment.

In addition, the \$575.95 standardized Federal per diem rate may receive these **facility-level adjustments**:

- A hospital wage index adjustment;
- A rural location adjustment;
- A teaching status adjustment;
- A COLA adjustment for IPFs in Alaska and Hawaii; and
- An emergency department (ED) adjustment.

Outliers

Additional payments will be made for those cases that are high cost outliers. A case will fall into this category if the estimated cost of the case exceeds an outlier threshold (the PPS payment plus a fixed loss amount).

Interrupted Stays

The IPF PPS includes a three-day policy for interrupted stays. An interrupted stay is a case in which an IPF patient is discharged and then admitted to any IPF. Thus, if a patient is discharged from an IPF and admitted to any IPF within three consecutive days of the discharge from the original IPF stay, the stay is treated as continuous for purposes of the variable per diem adjustment and any applicable outlier payment.

Stop-Loss Provision

The IPF PPS includes a stop-loss provision for the three-year transition to PPS to reduce the financial risk for IPFs that experience substantial reductions in Medicare payments during the period of transition to the IPF PPS.

During the transition to IPF PPS, the stop-loss provision ensures each facility's average payment per case under IPF PPS is no less than a minimum percentage of its aggregate payment under the TEFRA.

In the first year seventy-five percent of total payment would be TEFRA payments, and the remaining 25 percent would be IPF PPS payments, which would be guaranteed to be at least 70 percent of the TEFRA payments. The resulting 92.5 percent of TEFRA payments is the sum of 75 percent and 25 percent times 70 percent (which equals 17.5 percent).

Billing Changes

The IPF PPS will bring a few changes to IPFs but most of the billing principles and practices used under the TEFRA will remain the same. In *Chapter 3—Billing*, there is a billing review along with several claim examples reflecting these guidelines.

Correct Coding

Correctly coding ICD-9-CM diagnosis and procedure codes is very important because these codes have a pivotal role in claim adjudication. In *Chapter 3—Billing*, this issue is reviewed along with other Medicare billing requirements for IPF services related to IPF PPS.

Processing Bills Between January 1, 2005 and April 4, 2005

CMS will not have the Fiscal Intermediary Shared System (FISS) updated with the necessary changes to accommodate the new IPF PPS claims processing and payment requirements before April 4, 2005. Yet, an IPF which transitions to IPF PPS during this timeframe (January 1, 2005 and April 1, 2005) must follow the PPS billing requirements as if it is being paid under the PPS so that FIs can make accurate and timely adjustments to all claims processed during this period.

Thus, IPF claims submitted between January 1, 2005, and April 4, 2005 will be processed under the current TEFRA methodology, but beginning on or after April 4, 2005, FIs will mass adjust these claims to reflect the proper IPF PPS blended-payment. The mass adjustments should be completed by July 1, 2005.

This process will only affect those IPFs whose cost reporting periods begin on or after January 1, 2005 but before April 1, 2005.

Patients Who Are Currently Inpatients When Transition to PPS Occurs

If a patient's stay begins prior to and ends on or after an IPF's fiscal year start date under the IPF PPS, payment to the IPF will be based on IPF PPS rates and rules.

Thus, **the IPF should review its Medicare claim submission history** before submitting a new claim to Medicare for each patient. There is no split billing, so IPFs should take the following actions where appropriate:

- If an IPF did not submit any interim bills prior to the IPF PPS implementation, the IPF should submit one bill using the coding guidelines below.
- If an IPF submitted only one interim bill to Medicare, it must submit a 117 type of bill using the proper coding guidelines to create a debit/credit adjustment to the claim paid prior to the PPS payment (see Pub. 100-04 of the Internet Only Manual, chapter 1, section 50.2). The adjusted claim will become the discharge claim under the new PPS and it will be used to issue a PPS payment to the IPF.

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- If an IPF submitted multiple interim bills, it must submit 118 cancellation claims for all paid interim bills. After all of the cancellations are finalized, the IPF should submit one claim from admission through discharge using the IPF PPS coding mentioned below. This claim should be a discharge claim and it will be used to issue a PPS payment to the IPF.
- If the beneficiary's benefits were exhausted or patient is in a non-covered level of care prior to implementation of this PPS, then the IPF will continue to submit no-pay bills (TOB 110) to Medicare.

Hospital Reserve Days

Inpatient Hospital Lifetime Reserve Days

Each beneficiary has a lifetime reserve of 60 days of inpatient hospital services to draw upon after having used 90 days of inpatient hospital services in a benefit period. Payment is automatically made for the 60 lifetime reserve days after the 90 days of benefits have been exhausted unless a beneficiary elects not to use them (thus saving the reserve days for a later time).

A coinsurance amount equal to one-half of the inpatient hospital deductible applies to lifetime reserve days. For calendar year (CY) 2005, this amount equals \$456 per day.

Psychiatric Hospital Services

There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. This limitation applies only to services furnished in a psychiatric hospital therefore, once a Medicare beneficiary receives benefits for 190 days of care in a psychiatric hospital, no further benefits of this type are available to beneficiary.

The Common Working File (CWF) keeps track of days paid for inpatient psychiatric services and informs the Fiscal Intermediary (FI) on claims where the 190-day limit is reached.

Beneficiary Liability

Beneficiary liability will operate the same as under the previous cost-based, TEFRA payment system. Therefore, even if Medicare payments are below the cost of care for a patient, the patient cannot be billed for the difference in any case where a full DRG payment is made.

Generally, beneficiaries may be charged only for:

- Deductibles
- Coinsurance
- Noncovered services
- Noncovered days