Related MLN Matters Article #: MM3541

Date Posted: December 7, 2004

Related CR #: 3541

MMA – Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Implementation

Key Words

MM3541, CR3541, R384CP, IPF, PPS, Inpatient, Psychiatric, Prospective, Payment, MMA

Provider Types Affected

Inpatient psychiatric facilities (IPFs), including distinct part psychiatric units of acute care hospitals

Key Points

- The effective of the instruction is January 1, 2005.
- The implementation date is April 4, 2005.
- Medicare is changing the way it will pay for services provided to Medicare beneficiaries in IPFs, including distinct part psychiatric units, effective with discharges on or after January 1, 2005.
- IPFs PPS will replace the existing reasonable cost-based payment system under which the IPFs are currently paid.
- Changes will not be implemented in the Medicare systems until April 4, 2005.
- Fiscal intermediaries (FIs) will mass adjust claims submitted prior to April 4, 2005, once Medicare systems have implemented this PPS.
- IPFs must follow the PPS billing requirements for claims for discharges on or after January 1, 2005, as if Medicare were paying under the PPS; this is required so the mass adjustments can be made in an accurate and timely manner.

Billing Requirements

- Effective with cost reporting periods that begin on or after January 1, 2005, IPFs must bill or be aware of the following so FIs can accurately price and pay a claim under the IPF PPS:
    - Submit the claim on type of bill (TOB) 11x.

- Code the claim using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes based on principal diagnosis, up to eight additional diagnoses, and one principle procedure and up to five additional procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim.
- Submit one admit-through-discharge claim for the stay upon discharge. (Should the stay be exceptionally long, interim bills based on 60-day intervals may be submitted. However, the final PPS payment will be based on the discharge bill.)
- Adjustment bills will be accepted, but late charge bills will not be allowed.
- While all patient status (i.e., discharge disposition codes) for TOB 11x are valid, there are no special policies related to transfers. (The same patient status codes applicable under inpatient PPS for same day transfers [with Condition Code 40] are applicable under IPF PPS.)
- Indicate on the claim, under revenue code 0901, the total number of electroconvulsive therapy (ECT) treatments provided to the patient during their IPF stay listed under "Service Units." Use code ICD-9-CM procedure code 94.27 in the procedure code field and use the date of the last ECT treatment provided the patient during their stay.
- IPFs continue to be subject to the one-day payment window for outpatient bundling rules.
- The payer at the patient's admission to the IPF is responsible for the patient's entire stay, e.g., when a patient moves from traditional Medicare to a Medicare Advantage plan, or vice versa, during the stay.
- There are no grace days allowed under IPF PPS. Therefore, the date the beneficiary is notified of the provider's intent to bill (Occurrence Code 31) is the last covered day for that patient.

Transition

- The IPF PPS will be phased-in over 3 years from the current cost-based reimbursement and all IPFs must go through the transition, **except for new IPF providers**. (See Change Request (CR) 3541 for definitions of "new providers," who will be paid immediately at 100 percent of the IPF PPS rate.)
- The transition period is as follows:
  - Year 1 (effective for cost reporting periods on or after January 1, 2005): 75 percent of payment will be at the current Tax Equity and Fiscal Responsibility Act (TEFRA) rate and 25 percent at the IPF federal rate.
  - Year 2 (effective for cost reporting periods on or after January 1, 2006): 50 percent of payment will be at the TEFRA rate and 50 percent at the IPF PPS federal rate.
  - Year 3 (effective for cost reporting periods on or after January 1, 2007): 25 percent of payment will be at the TEFRA rate and 75 percent at the IPF PPS federal rate.
  - Commencing with cost reporting periods on or after January 1, 2008: payments will be based 100 percent on the IPF PPS rate.

Payment Information

- Some key points of interest regarding the payment rates are as follows:
  - The IPF PPS must be budget neutral; i.e., total payments under the IPF PPS must equal the total amount that would have been paid if the PPS had not been implemented.
  - The standardized federal per diem base rate, adjusted for budget neutrality, behavioral offset, outlier payments, and stop-loss payments is $575.95.
  - The federal per diem base rate is adjusted by all applicable patient and facility characteristics.
  - The first annual update to the IPF PPS will occur on July 1, 2006, and annual updates will occur yearly, thereafter on July 1. Please note that the annual update cycle is separate from the transition period.
  - The first annual update notice will be published in the Federal Register in the spring of 2006.

Patient-Level Adjustment

- Payments will be adjusted at the patient-level and those adjustments include the following:
  - A diagnosis-related group (DRG) specific adjustment for 15 specific DRGs as noted in the CR3541. Although an IPF will not receive a DRG specific adjustment for a principal diagnosis not found in one of the identified 15 psychiatric DRGs listed in CR 3541, the IPF will receive the federal per diem base rate and all other applicable adjustments. Please note the information regarding the "Code First" rules that immediately follow the list of these 15 DRGs in CR3541.
  - The IPF PPS also has comorbidity adjustments for 17 comorbidity groupings, each containing ICD-9-CM codes of comorbid conditions and these are also listed in CR3541. An IPF can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category.
  - The IPF PPS has an age adjustment that the facility will receive for each day of the stay as noted in CR3541. This age adjustment has 9 age categories (under age 45, over age 80, and categories in five year groupings in between the ages of 45 and 80).
  - There is a "variable per diem" adjustment that accounts for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. This variable adjustment, as shown in CR3541 declines each day of the patient's stay through day 21. After day 21, the variable per diem adjustment flattens out and remains the same for the remainder of the patient's stay.

Facility-Level Adjustment

- Payments will be adjusted at the facility-level and those adjustments include the following:
  - A wage index adjustment accounts for geographic differences in labor costs;
  - A 17% adjustment is allotted to facilities located in rural areas;
  - Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the average daily census raised to the power of 0.5150; further, the number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to January 1, 2005; and

- An adjustment will be provided for the first day of a psychiatric stay for IPFs with emergency departments as defined by CR3541.

Other Adjustments

- In addition to the patient-level and facility-level adjustments, there will be adjustments (further described in CR3541) for:
  - ECT;
  - Cost-of-living adjustments for IPFs located in Alaska and Hawaii, and
  - Payments for interrupted stays, outliers, and stop-loss.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3541.pdf* on the CMS website.

The official instruction (CR3541) regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R384CP.pdf* on the CMS website.

Providers may want to review MLN Matters article MM3678 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3678.pdf*), which clarified some aspects of IPF PPS. It clarified questions CMS had received from IPFs and the Medicare FIs.

If providers have any questions, they may contact their intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.