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Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3752

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Note: This article was updated on February 4, 2013, to reflect current Web addresses. All other information remains unchanged.

Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) - Further Clarifications

Provider Types Affected

Inpatient Psychiatric Facilities (IPF) Billing Medicare Fiscal Intermediaries (FIs) for services paid under the IPF Prospective Payment System (PPS)

Provider Action Needed



STOP – Impact to You

Physicians, suppliers and providers should note that this instruction is based on information contained in Change Request (CR) 3752 regarding the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS).



CAUTION – What You Need to Know

Note that CR 3752 clarifies recent questions CMS received from IPFs and the Medicare Fiscal Intermediaries (FIs) that service them, and corrects some aspects of Change Request (CR) 3678.



GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for further details regarding these clarifications.

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Background

For an overview of all of the policy and billing requirements related to IPF PPS, please see Change Request (CR) 3541, "Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)", Transmittal 384, dated December 1, 2004, at the following Centers for Medicare & Medicaid Services (CMS) website: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R384CP.pdf> on the CMS website.

The corresponding MLN Matters article can also be reviewed at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3541.pdf> on the CMS website.

Please also see the November 15, 2004 final rule (69 FR 66922) regarding the IPF PPS and note that CMS will be issuing a correction notice to that final rule

Change Request (CR) 3752 helps clarify some confusing aspects regarding the IPF PPS including:

- What constitutes a new IPF;
- A 'code first' example;
- A fix to the comorbidity table;
- Split billing instructions; and
- An extension to notify FIs of Emergency Department (ED) status.

What Constitutes a New IPF?

CMS defined a new IPF as a provider of inpatient hospital psychiatric services that:

- Meets the qualifying criteria for IPFs, set forth in 42 CFR §412.22, §412.23, §412.25, and §412.27; and
- Has not (under current ownership, previous ownership, or both) 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.

Note: This means if the provider ever had a TEFRA limit, CMS will use that TEFRA limit updated to current times. CMS will not consider the IPF to be a new provider, and the IPF therefore will receive the blended payment. This includes those providers that previously closed their psychiatric units and then re-opened the units. If those facilities had a TEFRA limit established, then CMS will update that TEFRA limit.

Change of ownership will have no impact on whether an IPF is considered a new IPF provider.

A 'Code First' Example

Diagnosis code 294.11 "Dementia in Conditions Classified Elsewhere with Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

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Four digit code 294.1 "Dementia in Conditions Classified Elsewhere," is designated as a "Code first" diagnosis indicating that all five digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the "code first" rule.

The three-digit code 294 "Persistent Mental Disorders Due to Conditions Classified Elsewhere" appears in the ICD-9-CM as shown in the table below:

294	PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE
	<p>294.1 Dementia in Conditions Classified Elsewhere</p> <p>Code first any underlying physical condition, as:</p> <p>Dementia in:</p> <ul style="list-style-type: none"> Alzheimer's disease (331.0) Cerebral lipidosis (330.1) Dementia with Lewy bodies (331.82) Dementia with Parkinsonism (331.81) Epilepsy (345.0 – 345.9) Frontal dementia (331.19) Frontotemporal dementia (331.19) General paresis [syphilis] (094.1) Hepatolenticular degeneration (275.1) Huntington's chorea (333.4) Jacob-Creutzfeldt disease (046.1) Multiple sclerosis (340) Pick's disease of the brain (331.11) Polyarteritis nodosa (446.0) Syphilis (094.1) <p>294.10 Dementia in Conditions Classified Elsewhere without Behavioral Disturbances NOT ALLOWED AS PRINCIPAL DX</p> <p>294.11 dementia in Conditions Classified Elsewhere With Behavioral Disturbances NOT ALLOWED AS PRINCIPAL DX</p>

According to "code first" requirements, the provider would code the appropriate physical condition first. For example, note 333.4 "Huntington's Chorea" as the primary diagnosis code and 294.11 "Dementia In Conditions Classified Elsewhere With Behavioral Disturbances" as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding of a true "Code First" situation. In this example, the principal diagnosis groups to one of the 15 DRGs for which Medicare pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG, Medicare's systems (particularly the Pricer) would search the secondary diagnosis codes for a psychiatric code listed in the "Code First" list to assign a DRG adjustment.

A Fix to the Comorbidity Table - Comorbidity Chart (page 7 of CR 3541)

This chart is corrected as follows:

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Oncology Treatment	1400-2399 WITH a radiation therapy (92.21-92.29) OR chemotherapy code (99.25)
Chronic Obstructive Pulmonary Disease	V4611, V4612, 49121, 4941,5100, 51883, and 51884
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, and 9585
Drug and/or Alcohol Induced Mental disorders	2910, 2920, 29212, 2922, 30300, and 30400

Split Billing Instructions - Split Billing/Stays Prior to and Discharges After IPF PPS Implementation Date

CMS apologizes for the confusion regarding how IPFs should bill for patients in-house when the facility's cost report begin date triggers the transition to IPF PPS. In CR 3678, CMS stated that IPFs had to split the bill in these instances. During the CMS training session with FIs, it was determined that providers did not have to split the bill, and FIs could override reason code 32061.

Therefore, for IPFs that have already split their bill because they received reason code 32061 and/or because they followed the instructions in CR 3678, you must cancel your pre-transition bill and re-bill your claim, showing all services from the admission date through discharge, as described in CR 3541. **This must be done by April 1, 2005**, so that mass adjustments can be appropriately applied. Your FI will be instructed to override the reason code, 32061, that forces you to split the bill.

For IPFs that have not split their bill, continue to follow the instructions in CR 3541. Your FI will override reason code 32061.

To summarize, IPFs should follow the instructions in CR 3541 (split billing not allowed) and ignore the instruction in CR 3678 regarding this issue.

Keep in mind that if your patient did not have Medicare benefits, exhausted his/her benefits, or is in a non-covered level of care at transition, you may continue to submit no-pay bills every 30 days.

An Extension to Notify Fiscal Intermediaries of Emergency Department (ED) Status - Date to Notify FIs of Emergency Department

Some FIs have requested an extension for their IPFs to notify them of their emergency room status. IPFs with cost reporting periods beginning between January 1, 2005 and March 1, 2005 shall have notified their FI by March 7, 2005. For all other cost report begin dates, IPFs should notify their FI 30 days prior to the cost report begin date.

CMS will allow FIs discretion in the manner in which they wish to be notified and the type of documentation they will require.

Additional Corrections

The following are also corrections to CR 3678 "Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)", Transmittal 444, dated January 21, 2005:

- Blood-clotting factors are **not** considered a pass-through cost paid outside the IPF PPS. Payment for the factors is made through the Coagulation Factor Deficits comorbidity adjustment.

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- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS. Information regarding nursing and allied health will be placed in the IPF PPS correction notice.
- For PIP providers, electroconvulsive therapy and outlier payments are made on the discharge bill and are not included in the PIP amount.

CR 3678 "Further Information Related to Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)", Transmittal 444, dated January 21, 2005, can be reviewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R444CP.pdf> on the CMS website.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R495CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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