

MLN Matters Number: MM3541

Related Change Request (CR) #: 3541

Related CR Release Date: December 1, 2004

Effective Date: January 1, 2005

Related CR Transmittal #: 384

Implementation Date: April 4, 2005

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

**Note:** This article was updated on May 12, 2013, to reflect current Web addresses. This article was previously revised on August 21, 2007, to add a reference to related MLN Matters article MM3678 (<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3678.pdf>), which clarified some aspects of IPF PPS. It clarified questions CMS had received from IPFs and the Medicare FIs. All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed



#### STOP – Impact to You

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.



#### CAUTION – What You Need to Know

This article provides information needed to implement Medicare standard systems for IPF PPS. Be aware of the full impact of this change on your facility's billing processes.



#### GO – What You Need to Do

Familiarize your billing staffs with this information and the details in related CR 3541. Staff should avail themselves of additional training and materials, to be

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available from your Medicare fiscal intermediary (FI), to ensure accurate and timely payments from Medicare under this new payment system.

## Background

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IPFs are certified under Medicare as inpatient psychiatric hospitals and distinct psychiatric units of acute care hospitals that:

- 1) have been excluded from the hospital inpatient PPS under the Social Security Act (SSA, Section 1886(d)((1)(B)(i)); and
- 2) are included for purposes of Medicare payment.

The IPF PPS will replace the existing reasonable cost-based payment system under which the IPFs are currently paid.

### *Statutory Requirements*

- The Balanced Budget Refinement Act (BBRA of 1999) requires that a budget neutral, per diem PPS for IPFs include an adequate patient classification system, reflecting the differences in patient resource use and costs among psychiatric hospitals and psychiatric units of acute care hospitals, be implemented for cost reporting periods beginning on or after October 1, 2002. This will replace the reasonable cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) payment system.
- The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 902) amended section 1871 (a) of the Act stating that the timeliness for regulations will not exceed three years after publication of the preceding proposed or interim final regulation except under exceptional circumstances. This final rule finalizes the provisions set forth in the November 28, 2003 proposed rule. 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 November 15, 2004 final rule (69 CFR 66922).

### *Affected Medicare Providers*

IPFs are certified under Medicare as inpatient psychiatric hospitals—institutions that are primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of the mentally ill person. An IPF maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill person and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution.

Distinct psychiatric units must meet the clinical record and staffing requirements to be considered a “psychiatric hospital.” Both psychiatric hospitals and distinct psychiatric units of acute care hospitals are referred to in the IPF PPS rule as

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"inpatient psychiatric facilities." IPFs are identified by the last four digits of the Medicare provider number, which range between "4000" and "4499" for psychiatric hospitals and "Sxxx" and "Mxxx."

Hospitals excluded from the IPF PPS include the following:

- Veterans Administration hospitals;
- Hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403;
- Hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U. S. C. 1395b-1) or §222(a) of Public Law 92-603 (42 U. S. C. 1395b-1);
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries. Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c);
- IPFs in acute care hospitals that are currently paid in accordance with demonstration projects; and
- Freestanding IPFs (provider number xx-4000 through xx-4499) in Maryland will be paid under the IPF PPS, though distinct part psychiatric units located in Maryland (fourth position of provider number is 'S') will be waived from the IPF PPS. There are currently no critical access hospitals in Maryland.

As mentioned previously, this article provides some basic information about this new PPS, but it is very important that affected providers become familiar with the full details of the official instruction issued by the Centers for Medicare & Medicaid Services (CMS) regarding this new system. The CR related to this article, CR 3541, has been issued to your FI and provides the CMS policy, business requirements, and information on the data elements of the Provider-Specific File that is relevant to the IPF. CR 3541 may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R384CP.pdf> on the CMS website.

## Key Provisions

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While affected providers need to be familiar with the full details of CR3541, some of the key provisions are as follows:

### *Implementation Date*

This change will not be implemented in Medicare systems until April 4, 2005. However, the changes are effective with claims for discharges on or after January 1, 2005. Since you may submit claims for affected services prior to April 4, 2005, CMS has instructed your FI to mass adjust claims submitted prior to April 4, once

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Medicare systems have implemented this PPS. **Your FI should complete such mass adjustments by July 1, 2005.**

**Remember:** IPFs must follow the PPS billing requirements for claims for discharges on or after January 1, 2005 as if Medicare systems were paying under the PPS. This is required so the mass adjustments can be made in an accurate and timely manner.

### *What are those 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 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. But 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 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. Thus, the date the beneficiary is notified of your intent to bill (Occurrence Code 31) is the last covered day for that patient.

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### ***Transition (Phase-in Implementation)***

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 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 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***

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, 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 Adjustments***

Payments will be adjusted at the patient level and those adjustments include the following:

- A 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

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diagnosis not found in one of the identified 15 psychiatric DRGs listed in CR3541, 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 Adjustments***

There are also the following adjustments related to the facility:

- 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.
- 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 provided for electroconvulsive therapy, cost-of-living adjustments for IPFs located in Alaska and Hawaii, and payments for interrupted stays, outliers, and stop-loss. These payment factors are all further described in CR3541.

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## Additional Information

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Affected providers must be familiar with the official instruction on this new system. That instruction can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R384CP.pdf> on the CMS website.

Please look for further educational opportunities and information from your FI regarding this new PPS.

If you have any questions or need additional information, 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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