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MLN Matters Number: MM5129

Related Change Request (CR) #: 5129

Related CR Release Date: June 9, 2006

Effective Date: July 1, 2006

Related CR Transmittal #: R39GI and R978CP

Implementation Date: July 3, 2006

**Note:** This article was updated on November 8, 2012, to reflect current Web addresses. This article was previously revised on August 30, 2006, to provide a more efficient address for accessing the IPF PPS final rule published on May 9, 2006. All other information remains the same.

## Update to the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) for Rate Year 2007

### Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) for inpatient psychiatric services furnished to Medicare beneficiaries

### Impact on Providers

This article is based on Change Request (CR) 5129 which informs your intermediary that changes are required as part of the annual IPF PPS update for RY 2007. These changes include the following:

- Market basket update;
- New CBSA designations used for assigning a wage index value; and
- The PRICER update.

### Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published a Final Rule in the Federal Register ([http://www.access.gpo.gov/su\\_docs/fedreg/a041115c.html](http://www.access.gpo.gov/su_docs/fedreg/a041115c.html)) establishing the prospective payment system (PPS) for Inpatient Psychiatric Facilities (IPF) under the Medicare program (in accordance with provisions of Section 124 of Public Law

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106-113, the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA)).

Payments to IPFs under the IPF PPS are based on a Federal Per Diem base rate that:

- Includes inpatient operating and capital-related costs (including routine and ancillary services); and
- Excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

CMS is required to make updates to the IPF PPS annually. In addition:

- The Rate Year (RY) update is effective July 1 - June 30 of each year; while
- The Diagnosis Related Groups (DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

**Note:** This is the first Rate Year update to the IPF PPS.

CR5129 announces that, effective July 1, 2006, all IPFs (freestanding psychiatric hospitals and distinct part units of acute care hospitals and critical access hospitals) must meet the physician certification requirements specified in 42 CFR 424.14. Certification is required at the time of admission or as soon thereafter as is reasonable and practicable.

The first re-certification is required as of the 12<sup>th</sup> day of hospitalization and subsequent re-certifications are required at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days. The physician must also re-certify that the patient continues to need, on a daily basis, active inpatient psychiatric treatment furnished directly by or requiring the supervision of IPF personnel.

Also, CR5129 identifies changes that are required as part of the annual IPF PPS update from the RY 2007 IPF PPS Final Rule published on May 9, 2006. This Final Rule is available at

<http://www.gpo.gov/fdsys/search/home.action on the Internet>.

These changes are **applicable to IPF discharges** occurring during the rate year beginning on July 1, 2006, through June 30, 2007. These changes include the following:

### ***1. Market Basket Update***

CMS is now using the new Rehabilitation/Psychiatric/Long-Term Care (RPL) market basket to update the IPF PPS portion of the blended payment rate (that is, the federal per diem base rate).

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A re-based, 2002-excluded hospital market basket is used to update the cost-based portion (TEFRA). It is effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

## ***2. PRICER Updates for IPF PPS Rate Year (RY) 2007, (July 1, 2006 – June 30, 2007)***

- The Federal per-diem base rate is \$595.09.
- The fixed-dollar loss threshold amount is \$6,200.
- The revised standardization factor is 82.54 percent.
- The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2006, but before January 1, 2007, is 50 percent PPS and 50 percent TEFRA.
- The transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is 75 percent PPS and 25 percent TEFRA.
- Core-Based Statistical Area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2006. There will be no separate transition blend under IPF PPS for conversion to the CBSA-based labor market areas.
- The labor-related share is 75.665 percent.
- The non-labor related share is 24.335 percent.
- The Electroconvulsive Therapy (ECT) rate is \$256.20.

## ***3. Teaching Status Adjustment***

The teaching adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount computed in the cost report is adjusted through lump sum payments/recoupments when the cost report is filed and later settled.

## ***4. Electroconvulsive Therapy (ECT) Update***

The new update methodology for the ECT rate is to use the CY 2005 ECT rate as a base and update that amount by the market basket increase each rate year. This methodology is consistent with the methodology CMS uses to update the federal per-diem base rate because CMS will use the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket increase to increase both rates. The ECT adjustment per treatment is \$256.20 for RY 2007.

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### ***5. Diagnosis Related Group (DRG) Adjustment Update***

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or in the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the identified 15 psychiatric DRGs, the IPF receives the federal per diem base rate and all other applicable adjustments.

Table 1 below lists the new FY 2006 ICD-9-CM diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. When coded as a principal diagnosis, the IPF receives the correlating DRG adjustment. This table is only a listing of new codes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

**TABLE 1. FY 2006 New Diagnosis Codes**

ICD-9-CM Diagnosis Code	Description	DRG
291.82	Alcohol induced sleep disorders	521, 522, 523
292.85	Drug induced sleep disorders	521, 522, 523
327.00	Organic insomnia, unspecified	432
327.01	Insomnia due to medical condition classified elsewhere	432
327.02	Insomnia due to mental disorder	432
327.09	Other organic insomnia	432
327.10	Organic hypersomnia, unspecified	432
327.11	Idiopathic hypersomnia with long sleep time	432
327.12	Idiopathic hypersomnia without long sleep time	432
327.13	Recurrent hypersomnia	432
327.14	Hypersomnia due to medical condition classified elsewhere	432
327.15	Hypersomnia due to mental disorder	432
327.19	Other organic hypersomnia	432

Table 2 below lists ICD-9-CM diagnosis codes whose titles have been modified in FY 2006. Title changes do not impact the DRG adjustment. When used as a principal diagnosis, these codes still receive the correlating DRG adjustment. This table is only a listing of FY 2006 changes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

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**TABLE 2. Revised Diagnosis Code Titles**

ICD-9-CM Diagnosis Code	Description	DRG
307.45	Circadian rhythm sleep disorder of nonorganic origin	432
780.52	Insomnia, unspecified	432
780.54	Hypersomnia, unspecified	432
780.55	Disruption of 24 hour sleep wake cycle, unspecified	432
780.58	Sleep related movement disorder, unspecified	432

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the DRG adjustment factors, the ICD-9-CM coding changes, and the DRG classification changes, are shown below in Table 3. Please note these are the same adjustment factors that are currently in effect, since implementation.

**TABLE 3. FY 2006 DRGs and Adjustment Factor**

DRG	DRG Definition	Adjustment Factor
DRG 424	O.R. Procedure with Principal Diagnosis of Mental Illness	1.22
DRG 425	Acute Adjustment Reaction & Psychosocial Dysfunction	1.05
DRG 426	Depressive Neurosis	0.99
DRG 427	Neurosis, Except Depressive	1.02
DRG 428	Disorders of Personality & Impulse Control	1.02
DRG 429	Organic Disturbances & Mental Retardation	1.03
DRG 430	Psychoses	1.00
DRG 431	Childhood Mental Disorders	0.99
DRG 432	Other Mental Disorder Diagnoses	0.92
DRG 433	Alcohol/Drug Abuse or Dependence, Leave Against Medical Advice (LAMA)	0.97
DRG 521	Alcohol/Drug Abuse or Dependence with CC	1.02
DRG 522	Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy without CC	0.98
DRG 523	Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without CC	0.88
DRG 12	Degenerative Nervous System Disorders	1.05
DRG 23	Non-traumatic Stupor & Coma	1.07

In order to maintain consistency with the IPPS, for discharges occurring on or after October 1, 2005, ICD-9-CM code 305.1, Tobacco Use Disorder, will not be a covered principal diagnosis under the IPF PPS.

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All IPFs must follow the ICD-9-CM Official Guidelines for Coding and Reporting, including Code First. The ICD-9-CM Official Guidelines for Coding and Reporting can be found at <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf> on the Internet.

### ***6. Comorbidity Adjustment Update***

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay (LOS) or affect both treatment and LOS.

CMS is using the FY 2006 GROUPER, Version 23.0, effective for discharges occurring on or after October 1, 2005.

Table 4 lists the updated FY 2006 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. Table 4 only lists the FY 2006 new codes and does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

**TABLE 4. FY 2006 New ICD-9-CM Codes Applicable for the Comorbidity Adjustment**

ICD-9-CM Diagnosis Code	Description	DRG	Comorbidity Category
585.3	Chronic kidney disease, Stage III (moderate)	315 - 316	Renal Failure, Chronic
585.4	Chronic kidney disease, Stage IV (severe)	315 - 316	Renal Failure, Chronic
585.5	Chronic kidney disease, Stage V	315 - 316	Renal Failure, Chronic
585.6	End stage renal disease	315 - 316	Renal Failure, Chronic
585.9	Chronic kidney disease, unspecified	315 - 316	Renal Failure, Chronic
V46.13	Encounter for weaning from respirator [ventilator]	467	Chronic Obstructive Pulmonary Disease
V46.14	Mechanical complication of respirator [ventilator]	467	Chronic Obstructive Pulmonary Disease

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Since the purpose of the comorbidity adjustment is to account for the higher resource costs associated with comorbid conditions that are expensive to treat on a per diem basis, CMS is not providing a comorbidity adjustment for the following ICD-9-CM codes:

ICD-9-CM Code	Description
585.1	Chronic kidney disease, Stage I
585.2	Chronic kidney disease, Stage II (mild)

These conditions (585.1 and 585.2) are less costly to treat on a per diem basis because patients with these conditions are either asymptomatic or may have only mild symptoms.

Table 5 lists the invalid ICD-9-CM codes no longer applicable for the comorbidity adjustment. This table does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

**TABLE 5. FY 2006 Invalid ICD-9-CM Codes No Longer Applicable for the Comorbidity Adjustment**

ICD-9-CM Diagnosis Code	Description	DRG	Comorbidity Category
585	Chronic renal failure	315-36	Renal Failure, Chronic

CMS is aware that ICD-9-CM code 404.03 (hypertensive heart and renal disease, malignant, with heart failure and renal failure) has caused confusion, since this ICD-9-CM code is currently used to code an adjustment in two separate IPF comorbidity categories, (that is, both "Renal Failure, Chronic" and "Cardiac Conditions").

It more appropriately corresponds to the "Cardiac Conditions" comorbidity than to the "Renal Failure, Chronic" comorbidity. Therefore, to be more clinically cohesive and to eliminate confusion, CMS:

- Removed ICD-9-CM code 404.03 from the comorbidity adjustment category "Renal Failure, Chronic," but
- Retained ICD-9-CM code 404.03 in the "Cardiac Conditions" comorbidity category.

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the Comorbidity Category factors, the ICD-9-CM coding changes, and Comorbidity Category classification changes that are **currently** being paid are shown below in Table 6. Please note these are the same adjustment factors in place since implementation.

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**TABLE 6. FY 2006 Diagnosis Codes and Adjustment Factors for Comorbidity Categories**

Description of Comorbidity	ICD-9-CM Code	Adjustment Factor
Developmental Disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation Factor Deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal Failure, Chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V451, V560, V561, and V562	1.11
Oncology Treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled Diabetes-Mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe Protein Calorie Malnutrition	260 through 262	1.13
Eating and Conduct Disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious Disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac Conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic Obstructive Pulmonary Disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial Openings - Digestive and Urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe Musculoskeletal and Connective Tissue Diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

### **7. Payment Rate**

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services) but excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

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**Per Diem Rate**

Federal Per Diem Base Rate	\$595.09
Labor Share (0.75665)	\$450.27
Non-Labor Share (0.24335)	\$144.82

The rates for RY 2007 were published in the final rule and can also be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html> on the CMS website.

**8. The National urban and rural cost to charge ratios for the IPF PPS RY 2007**

Cost to Charge Ratio	Median	Ceiling
Urban	0.55	1.7179
Rural	0.71	1.7447

CMS is applying the national median Cost-to-Charge Ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

**Additional Information**

For complete details, please see the official instruction (CR5129) issued to your intermediary regarding this change. There are two transmittals associated with CR5129. The first transmittal at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R39GI.pdf> and contains information on the physician certification requirements. The second transmittal is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R978CP.pdf> on the CMS website and includes claims processing information.

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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