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Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3678

MLN Matters Number: MM3678

Related CR Release Date: January 21, 2005

Related CR Transmittal #: 444

Effective Date: Cost reporting periods beginning on or after January 1, 2005

Implementation Date: April 4, 2005

Further Information Related to Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS)

Note: This article was updated on March 28, 2013, to reflect current Web addresses. All other information remains unchanged.

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

This article contains additional information regarding general policy and billing issues to help clarify the processes under the IPF PPS, particularly for facilities under the IPF PPS as of January 1, 2005.

IMPORTANT NOTE: Since CR3678 was released, the Centers for Medicare & Medicaid Services (CMS) has issued another CR (CR3752) that clarifies some issues further and makes several corrections to CR3678 and this instruction. Specifically, the following are corrections to CR3678, "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.

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.

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When reading this instruction, please be sure to also read the MLN Matters article MM3752, which contains these clarifications and corrections. You will find MM3752 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm3752.pdf> on the CMS website.

Background

Related CR3678 clarifies some aspects of IPF PPS. It does not replace CR3541 (Transmittal 384, dated December 1, 2004), but it clarifies recent questions CMS has received from IPFs and the Medicare FIs that service those providers in processing their Medicare claims.

You can find CR3541, an overview of all of the policy and billing requirements related to IPF PPS, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R384CP.pdf> on the CMS website. Its related MLN Matters article is at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3541.pdf> on the CMS website.

CMS will be issuing a Correction Notice to the Inpatient Psychiatric Facility Prospective Payment System final rule (Volume 69, Number 219, page 66922), published November 15, 2004, to make technical corrections which will include the following clarifications:

Labor-Related Share

- There is an inconsistency in the labor-related share between portions of the final rule and CR 3541, published December 1, 2004.
 - The current labor-related share is **0.72247**.

Teaching Status Adjustment

Teaching facilities will receive an adjustment that is measured as one plus the ratio of interns and residents to the Average Daily Census (ADC), the sum of which is raised to the power of 0.5150. The number of interns and residents is capped at the level indicated on the latest cost report submitted by the IPF prior to November 15, 2004.

Calculating the Electroconvulsive Therapy (ECT) Payment

The ECT amount of \$247.96 is subject to COLA and wage adjustments. To calculate the adjusted amount, multiply \$247.96 by the labor share (0.72247) and by the area wage index. Then multiply \$247.96 by the non-labor share (0.27753) and by any applicable COLA. The sum of these two products is the adjusted per-treatment ECT amount.

Multiply the amount by the number of ECT occurrences and add it to the Federal per diem payment to compute the total PPS payment.

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The ECT amount itself does not receive any facility or patient level adjustments; it is added to the Federal per diem payment after those adjustments have been applied. ECT payments and charges are taken into account when calculating the outlier threshold and outlier payment.

Calculating Outlier Payments

To understand how Medicare calculates outlier payments under the IPF PPS, CMS offers the following explanation:

Calculate the Adjusted Fixed Dollar Loss Threshold

- Threshold amount = \$5,700
- Multiply the threshold amount by the labor share (0.72247) and the area wage index.
- Multiply the threshold amount by the non-labor share (0.27753) and any applicable COLA (Alaska or Hawaii).
- Add these two products and then multiply by any applicable facility-level adjustments (teaching, rural); and
- Add this amount to the sum of the federal per diem payment and ECT payment to obtain the adjusted threshold amount.

Calculate Eligible Outlier Costs

- Multiply reported hospital charges by the cost-to-charge ratio to calculate cost.
- Subtract the adjusted threshold amount from the cost. This is the amount subject to outlier payments.
- Divide this amount by the length of stay to calculate the per diem outlier amount.
- For days 1 through 9, multiply this per diem outlier amount by 0.80.
- For day 10 and thereafter, multiply the per diem outlier amount by 0.60.
- The sum of these two amounts is the total outlier payment.

Additional Clarifications

- The effective date of the system is for discharges (or “through” dates for interim bills) occurring during cost reporting periods beginning on or after January 1, 2005.
- Although the IPF PPS new payment system is effective January 1, 2005, transition is based on a providers’ cost reporting year. IPF providers will begin the new IPF PPS system at the beginning of their new cost reporting period.

If an IPF provider has their cost reporting period starting on October 1, 2005, then October 1, 2005 will be:

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- The beginning date of their first transition year to the IPF PPS, and
- The date that they begin billing under the new IPF PPS system.

If an IPF provider has their cost reporting period starting on January 1, 2005, then January 1, 2005 will be:

- The beginning date they will begin billing under the new IPF PPS, and
- The beginning date of their first transition year.
 - CMS has received a number of questions concerning what is considered a "new IPF," and will be issuing additional guidance shortly regarding what constitutes a new IPF.
 - Providers should notify their FI 30 days prior to the start of the provider's fiscal year, if they believe they are entitled to the Emergency Department (ED) adjustment, to determine if their FI requires additional information or documentation. **However, providers whose cost reporting periods begin January 1, 2005 through March 1, 2005 should have contacted their FI on this issue prior to March 7, 2005.**
 - **Psychiatric units of Critical Access Hospitals (CAHs) are reimbursed under the IPF PPS.** In CR 3541, dated December 1, 2004, under the heading, "Affected Medicare Providers," the second bulleted paragraph contained an error. The paragraph should read as follows:

"Veterans Administration Hospitals, hospitals that are reimbursed under State cost control system 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), and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are not included in the IPF PPS. Payment to foreign hospitals will be made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c)."
 - CMS will be providing guidance on the National Cost to Charge Ratios which will be established using the most current IPF data available. The provider specific file required to calculate the national cost to charge ratios is under development.
 - Age adjustment is determined as of admission date.
 - Code First Chart (page 6 of CR 3541). The last row containing code 320.7 should be deleted. CMS is including a table (See Attachment 1 of CR 3678, the official instruction issued to your intermediary), that shows what adjustment factors apply. The Code First example provided on page 7 of CR

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3541 was in error and a corrected example may be found on pages 3 and 4 of CR 3678.

- The ICD-9-CM procedure codes for oncology treatments are 92.21 through 92.29 and 99.25.
- Comorbidity chart (page 7 of CR 3541) should have reflected the following:
- Oncology Treatment, 1400 through 2399 with a radiation therapy or chemotherapy code 92.21 – 92.29 or 99.25, instead of V58. or V58.1.
- Chronic Obstructive Pulmonary Disease, delete code V461 and add codes V4611 and V4612.
- For IPFs that are distinct part psychiatric units, Total Medicare inpatient routine charges will be obtained from the PS&R report associated with the latest settled cost report. If PS&R data is not available,
- Estimate Medicare routine charges estimated by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6.
- Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.
- To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, part III, column 8, line 31 plus Worksheet D, Part IV, column 7, line 101). All references to worksheet and specific line numbers should correspond with the subprovider identified as the IPF unit that is the letter "S" or "M" in the third position of the Medicare provider number.
- Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

More information is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html> on the CMS website.

Payment to Hospitals and Units excluded from the acute Inpatient Prospective Payment System for Direct Medical Education (DGME) and Nursing & Allied Health (N&AH) Education for Medicare Advantage Beneficiaries

Current IPFs are already following the requirements in CR 2476, Transmittal A-03-007, published on February 3, 2003, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A03007.PDF> on the CMS website.

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New IPFs and IPF Distinct Part Units located in a Critical Access Hospital should familiarize themselves with these instructions. **There is no authority for IPFs to bill for the indirect medical education as is done under the IPPS.**

Stays Prior to and Discharge After IPF PPS Implementation Date

Cost Report Period begins Prior to April 1, 2005:

Until the IPF PPS system changes are in place, IPF providers should continue to follow current billing instructions when patients are in the facility over the fiscal year begin date, i.e., split the bill. Once the changes are implemented, the IPF providers should follow the billing instructions as outlined in CR 3541. These instructions include the criteria for canceling and rebilling if the stay crosses the provider's PPS effective date.

For IPF providers, the claims submitted prior to their PPS effective date should only be canceled if the stay contains at least one benefit day applied on or after the PPS effective period. Stays that are benefits exhausted or noncovered prior to the provider's PPS effective date should not be canceled and rebilled as one stay. For patients admitted into the IPF after the PPS effective date, our system will automatically adjust those bills for the IPF.

Related Instructions

CR3541, an overview of all of the policy and billing requirements related to IPF PPS (Transmittal 384, dated December 1, 2004), can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R384CP.pdf> on the CMS website.

The MLN Matters article related to CR3541 can be found at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3541.pdf> on the CMS website.

In addition, the November 15, 2004 final rule in the Federal Register (Volume 69, Number 219, page 66922) can be found at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms1213f.pdf> on the CMS website.

Additional Information

For complete details on these clarifications, 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/R444CP.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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