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Learn about these Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) topics:

- Background
- Certifications and recertifications
- Determining IPF PPS payments
- IPF PPS fiscal year (FY) 2020 update
- Inpatient Psychiatric Facility Quality Reporting (IPFQRP)
- Resources

BACKGROUND

Since January 2005, Medicare makes IPF payments to inpatient psychiatric hospitals and certified inpatient psychiatric units in acute care and critical access hospitals, collectively known as IPFs, for psychiatric services to Medicare patients.

Medicare covers patients for psychiatric conditions in psychiatric hospitals or DP psychiatric units for 90 days per benefit period, with a 60-day lifetime reserve. Medicare pays for 190 days of inpatient psychiatric hospital services during a patient’s lifetime. This 190-day lifetime limit applies to psychiatric services in freestanding psychiatric hospitals, but not to inpatient psychiatric services in general hospitals or DP IPF units.
CERTIFICATIONS AND RECERTIFICATIONS

Medicare requires physician certifications and recertifications for IPF stays. Certification begins with the inpatient admission order. The certification statement helps Medicare pay only for appropriate services. Medicare Part A pays for inpatient services in an IPF if a physician certifies and recertifies the need for services based on the following requirements:

- A physician must certify:
  - Inpatient psychiatric services for treatment that could reasonably be expected to improve the patient’s condition or for diagnostic study.
    - A qualified, licensed physician must order the patient’s admission and have admitting privileges at the hospital according to State law. It must be a physician who is knowledgeable about the patient’s hospital course, medical plan of care, and current condition. The physician may not delegate the decision (order) to another individual not authorized by the State to admit patients or who does not have admitting privileges applicable to that patient by the hospital’s medical staff.

- Timing of certifications and recertifications:
  - Certification is required at admission, or as soon as reasonable and practicable, and the physician must complete it and document it in the medical record prior to patient discharge.
  - The first recertification must occur by the 12th day of hospitalization.
  - Medicare requires subsequent recertifications at least every 30 days. The utilization review committee can establish different review intervals on a case-by-case basis, such as every third day.

- Content of the recertification must include:
  - Documentation that the inpatient services furnished since the previous certification or recertification were, and continue to be, required for treatment, and could reasonably be expected to improve the patient’s condition or for diagnostic study.
  - Hospital records that document intensive treatment services, admission and related services for diagnostic study, or equivalent services.
  - Documentation that the patient needs daily active treatment furnished directly by, or under the supervision of, IPF personnel.

The physician responsible for the case, or another physician with knowledge of the case authorized by the responsible physician or the hospital’s medical staff, must sign the certifications and recertifications.
DETERMINING IPF PPS PAYMENTS

Federal law requires Medicare to pay a per diem base rate adjusted by factors for facility and patient characteristics that account for variation in patient resource use. The IPF must provide all necessary covered services directly or under arrangement to a Medicare patient. The IPF PPS payment is payment in full for all IPF services.

The IPF PPS does not include payment on a fee schedule basis for physicians under 42 CFR § 415.102(a) such as physician assistants, nurse practitioners and clinical nurse specialists, certified nurse-midwives, qualified psychologist services, and certified registered nurse anesthetists. Medicare pays covered professional services separately under Part B.

Under the IPF PPS, the Federal per diem base rate includes all costs for a patient in the IPF, including inpatient operating and capital-related costs (routine and ancillary services). It excludes pass-through costs, such as bad debts and graduate medical education. The Federal government calculates the IPF PPS per diem payment after adjusting the IPF PPS per diem base rate for facility and patient characteristics.

- **Facility characteristics:**
  - Medicare adjusts the labor portion of the Federal per diem base rate to account for geographic differences with an appropriate IPF wage index.
  - For FY 2020, Medicare aligned the IPF wage index data with the concurrent IPPS wage index data by removing the 1-year lag of the pre-floor, pre-reclassified IPPS hospital wage index, upon which the IPF wage index is based. Medicare also updated the IPF labor-related share and the IPF wage index including adoption of a new OMB designation.
  - IPFs in a rural location get a 17 percent rural adjustment.
  - IPFs with a qualifying emergency department (ED) get a 12 percent higher payment adjustment for the first day of stay.
  - Teaching hospitals get payment to account for indirect medical education costs.
  - The non-labor portion (NLP) of the Federal per diem base rate is adjusted by a cost of living adjustment (COLA) factor to account for a higher cost of living for IPFs in Alaska and Hawaii.

- **Patient characteristics:**
  - Medicare Severity-Diagnosis Related Group (MS-DRG) adjustment, based on the principal psychiatric diagnosis
  - Age
  - Presence of specified active comorbidities
  - Length of stay (LOS) (a variable per diem adjustment)
IPFs get additional payments for:

- The number of electroconvulsive therapy (ECT) treatments furnished.
- Outlier cases, which are cases with extraordinarily high costs. An IPF is eligible for an outlier payment when its estimated total cost for a case exceeds a fixed dollar threshold (multiplied by the IPF’s facility-level adjustments for wage index, rural location, teaching status, and location in Alaska or Hawaii) plus the Federal per diem payment amount for the case. To get the outlier payment amount:
  - First, calculate the total estimated cost by multiplying the IPF charges by the cost-to-charge ratio (CCR).
  - Second, subtract the sum of the adjusted outlier threshold amount and the total IPF PPS per diem payment for the case from the estimated cost.
  - Third, divide the result by the length of stay to get a daily outlier amount.
  - For each of the first 9 days, multiply the daily outlier amount by 80 percent (0.80).
  - For any days thereafter, multiply the daily outlier amount by 60 percent (0.60). The total outlier payment is the sum of all these amounts.
Inpatient Psychiatric Facility Prospective Payment

**Step 1.** Adjust the applicable Federal per diem base rate for geographic differences in wages and COLA (Alaska and Hawaii only). The applicable base rate is either the full Federal per diem base rate or the reduced Federal per diem base rate for IPFs that failed to report quality data.

\[
\text{Base rate} \times \text{Labor-Related Share (LRS)} = \text{Labor portion (LP)}
\]

\[
\text{LP} \times \text{wage index value} = \text{wage-adjusted labor share}
\]

\[
\text{Base rate} - \text{LP} = \text{non-labor portion (NLP)}
\]

\[
\text{NLP} \times \text{COLA (if applicable)} = \text{adjusted non-labor share}
\]

\[
\text{Wage and COLA-adjusted base rate}
\]

**Step 2.** Calculate the total adjustment factor for all other applicable facility and patient adjustments, except for the variable per diem adjustment and ED adjustment:

\[
\text{Rural adjustment} \times \text{teaching adjustment} \times \text{age adjustment} \times \text{DRG adjustment} \times \text{comorbidity adjustment} = \text{Adjustment Factor}
\]

**Step 3.** Multiply the adjustment factor from Step 2 by the wage and COLA-adjusted base rate from Step 1 to get a partially adjusted Federal per diem base rate, without variable per diem and ED adjustments.

\[
\text{Wage and COLA-adjusted base rate} \times \text{Adjustment factor} = \text{Partially adjusted base rate}
\]

**Step 4.** Multiply the partially adjusted Federal per diem base rate for each day of the stay by its applicable variable per diem adjustment factor. For Day 1, use a factor of 1.31 if the IPF has a qualifying ED and a factor of 1.19 if the IPF has no qualifying ED.
**Step 5.** Add the IPF PPS payments for each day of the stay to get the total IPF PPS payment amount.

\[
\text{IPF PPS payment Day 1} = \text{Variable per diem Day 1 (with ED factor, if applicable)} \times \text{Partially adjusted base rate}
\]

\[
\text{IPF PPS payment Day 2} = \text{Variable per diem Day 2} \times \text{Partially adjusted base rate}
\]

\[
\text{IPF PPS payment Day 3} = \text{Variable per diem Day 3} \times \text{Partially adjusted base rate}
\]

\[
\text{IPF PPS payment Day 4} = \text{Variable per diem Day 4} \times \text{Partially adjusted base rate}
\]

**Total = Sum of IPF PPS payments for each day of stay**

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**Payment for ECT Treatment**

Multiply the units of ECT treatment furnished during the stay by the applicable wage and COLA-adjusted ECT per treatment amount to get the total ECT payment. The applicable ECT per treatment amount is either the full ECT per treatment amount or the reduced ECT per treatment amount for IPFs that failed to report quality data.

\[
\text{Wage and COLA-adjusted ECT payment} = \left( \text{ECT per treatment amount} \times \text{LRS} = \text{ECT LP} \right) + \left( \text{ECT per treatment amount} - \text{ECT LP} = \text{ECT NLP} \right) \times \text{Total units of ECT treatment}
\]

ECT LP \( \times \) wage index value = wage-adjusted ECT labor share

ECT NLP \( \times \) COLA (if applicable) = adjusted ECT non-labor share
When submitting claims, record charges reasonably and consistently related to the costs for the items and services furnished to patients during an IPF stay. Even though IPFs get a per diem payment, providers must completely and accurately report their charges on claims. This information helps to accurately calculate outlier payments and periodically refine the IPF PPS.

For more information about the Federal per diem base rate, facility and patient adjustments, ECT payments, and outlier payments, refer to the November 15, 2004, IPF PPS Final Rule that started the IPF PPS.

**IPF PPS FY 2020 UPDATE**

The 2020 IPF PPS final rule revised the IPF market basket to reflect a 2016 base year and uses the concurrent hospital wage data as the basis of the IPF wage index.

Medicare cost report data for freestanding IPFs and hospital-based IPFs can help calculate the major market basket cost weights for a stand-alone IPF market basket. The Medicare average LOS for freestanding IPFs is calculated from data reported on Line 14 of Worksheet S–3, Part I. The Medicare average LOS for hospital-based IPFs is calculated from data reported on Line 16 of Worksheet S–3, Part I.

The FY 2020 update to the IPF PPS includes:

- **Market basket update:**
  - Medicare adjusts the per diem base rate annually by the IPF market basket update percentage. The FY 2020 IPF market basket update is 2.9 percent, minus a statutorily required productivity adjustment of 0.4 percentage point, minus a statutorily required additional adjustment of 0.75 percentage point, for a total FY 2020 update of 1.75 percent.
  - The Federal market basket update is reduced by 2 percentage points for IPFs that fail to report quality data. For FY 2020, IPFs out of compliance with quality data submission requirements get a negative update of -0.25 percent (1.75 percent–2.0 percentage points).
  - The Labor-Related Share (LRS) of the Federal per diem base rate for FY 2020: 76.9 percent.

- **Pricer updates:**
  - Federal per diem base rate: $798.55.
  - Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $782.85.
  - Fixed-dollar loss threshold amount: $14,960.
  - LRS (76.9 percent) of the Federal per diem base rate: $614.08.
  - LRS (76.9 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $602.01.
  - Non-labor-related share (23.1 percent) of the Federal per diem base rate: $184.47.
Non-labor-related share (23.1 percent) of the Federal per diem base rate with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $180.84.

ECT per treatment payment amount: $343.79.

ECT per treatment payment amount with the 2.0 percentage point reduction for IPFs out of compliance with quality data submission requirements: $337.03.

- The MS-DRG, comorbidity, age, teaching, and rural adjustment factors did not change.
- Medicare based the FY 2020 IPF wage index on the FY 2019 pre-floor, pre-reclassified hospital wage index.
- The wage index budget neutral factor is 1.0026. Medicare applies it to the per diem base rate when updating the base rate.
- National median CCRs that apply to IPFs in the following situations:
  - New IPFs that have not submitted their first cost report.
  - IPFs whose operating or capital CCR exceeds three standard deviations above the corresponding national geometric mean (the ceiling).
  - IPFs for which their Medicare Administrative Contractors get inaccurate or incomplete data to calculate a CCR.

### FY 2020 National CCRs

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<tr>
<th>CCR</th>
<th>Median</th>
<th>Ceiling</th>
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<tbody>
<tr>
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<tr>
<td>Rural</td>
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For more information about IPF PPS payment updates, refer to the [FY 2020 Final Payment Updates Addendum](#) and the [FY 2020 IPF PPS Final Rule](#).

### IPF QRP

Since FY 2014, Medicare subjects IPFs that do not report quality data to a 2.0 percentage point reduction to the annual update.

#### Quality Reporting Measures Required for the FY 2021 Annual Payment Update

- National Quality Forum (NQF) #0640—Hours of Physical Restraint Use
- NQF #0641—Hours of Seclusion Use
- NQF #0560—Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- NQF #0576—Follow-up After Hospitalization for Mental Illness
- N/A—Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention
N/A—Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the subset, Alcohol and Other Drug use Disorder Treatment at Discharge

N/A—Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment

N/A—Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge

NQF #1659—Influenza Immunization

N/A—Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

N/A—Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

N/A—Screening for Metabolic Disorders

NQF #2860—30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility

NQF #3205—Medication Continuation following Discharge from an IPF

Since FY 2017, IPFs must annually report aggregate total discharges as a single number as well as by payer, age strata, and diagnostic category.

For more information about quality data submission and reporting requirements, refer to the IPF QRP webpage.

RESOURCES

Table 1. IPF PPS Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
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