

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1101	Date: NOVEMBER 3, 2006
	Change Request 5287

Subject: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Medicare Claims Processing Manual with information that was published in the Federal Registers and that was previously distributed in other CRs regarding the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

This revision incorporates existing instructions in One-Time Notification Transmittals 384,444, 495,718, 868, and 978 about IPF PPS.

New / Revised Material

Effective Date: January 1, 2005

Implementation Date: December 4, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
N	3/190/Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
N	3/190.1/Background
N	3/190.2/Statutory Requirements
N	3/190.3/Affected Medicare Providers
N	3/190.4/Federal Per Diem Base Rate
N	3/190.4.1/Standardization Factor
N	3/190/190.4.2/Budget Neutrality
N	3/190.4.2.1/Budget Neutrality Components
N	3/190.4.3/Annual Update
N	3/190.4.4/Calculating the Federal Payment Rate
N	3/190.5/Patient-Level Adjustments

N	3/190.5.1/Diagnosis-Related Groups (DRGs) Adjustments
N	3/190.5.2/Application of Code First
N	3/190.5.3/Comorbidity Adjustments
N	3/190.5.4/Age Adjustments
N	3/190.5.5/Variable Per Diem Adjustments
N	3/190.6/Facility-Level Adjustments
N	3/190.6.1/Wage Index
N	3/190.6.2/Rural Location Adjustment
N	3/190.6.3/Teaching Status Adjustment
N	3/190.6.3.1/Full-Time Equivalent (FTE) Resident Cap
N	3/190.6.3.2/Reconciliation of Teaching Adjustment on Cost Report
N	3/190.6.4/Emergency Department (ED) Adjustment
N	3/190.6.4.1/Source of Admission for IPF PPS Claims for Payment of ED Adjustment
N	3/190.6.5/Cost-of-Living Adjustment (COLA) for Alaska and Hawaii
N	3/190.7/Other Payment Policies
N	3/190.7.1/Interrupted Stays
N	3/190.7.2/Outlier Policy
N	3/190.7.2.1/How to Calculate Outlier Payments
N	3/190.7.2.2/Determining the Cost-to-Charge Ratio
N	3/190.7.3/Electroconvulsive Therapy (ECT) Payment
N	3/190.7.4/Stop Loss Provision (Transition Period Only)
N	3/190.8/Transition (Phase-In Implementation)
N	3/190.8.1/Implementation Date for Provider
N	3/190.9/Definition of New IPF Providers Versus TEFRA Providers
N	3/190.9.1/New Providers Defined
N	3/190.10/Claims Processing Requirements Under IPF PPS
N	3/190.10.1/General Rules
N	3/190.10.2/Billing Period
N	3/190.10.3/Patient Status Coding
N	3/190.10.4/Reporting ECT Treatments
N	3/190.10.5/Outpatient Services Treated as Inpatient Services
N	3/190.10.6/Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period

N	3/190.10.7/Billing for Interrupted Stay
N	3/190.10.8/Grace Days
N	3/190.10.9/Billing Stays Prior to and Discharge After PPS Implementation Date
N	3/190.10.10/Billing Ancillary Services Under IPF PPS
N	3/190.10.11/Covered Costs Not Included in IPF PPS Amount
N	3/190.10.12/Same Day Transfer Claims
N	3/190.10.13/Remittance Advice-Reserved
N	3/190.10.14/Medicare Summary Notices and Explanation of Medicare Benefits
N	3/190.11/Benefit Application and Limits-190 Days
N	3/190.12/Beneficiary Liability
N	3/190.13/Periodic Interim Payments (PIP)
N	3/190.14/Intermediary Benefit Payment Report (IBPR)
N	3/190.15/Monitoring Implementation of IPF PPS Through Pulse
N	3/190.16/IPF PPS System Edits
N	3/190.17/IPF PPS PRICER Software
N	3/190.17.1/Inputs/Outputs to PRICER

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal 1101	Date: November 3, 2006	Change Request 5287
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SUBJECT: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)

I. GENERAL INFORMATION

A. Background: This transmittal revises Pub.100-04, Chapter 3, Inpatient Hospital Billing, by creating a new section (section 190) for Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). Specifically, this manual revision will update payment and billing policies regarding the IPF PPS. The manual will be updated with IPF PPS information that has been previously published in the **Federal Registers** and distributed in other Change Requests (CRs).

B. Policy: No changes are being made to the IPF PPS. The manual revisions in this transmittal simply reflect current policy that was previously distributed in CRs and various **Federal Registers**.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I S S	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
5287.1	Contractors and Maintainers shall be in compliance with the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, Section 190.	X				X			X	A/B MAC's

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I S S	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 1, 2005</p> <p>Implementation Date: December 4, 2006</p> <p>Pre-Implementation Contact(s): Dorothy Colbert (410) 786-9671; Sarah Shirey-Losso (410) 786-0187</p> <p>Post-Implementation Contact(s): Appropriate CMS Regional Office</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
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***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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190 - Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.1 - Background

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

This section and its subsections provide instructions about the IPF PPS. The IPF PPS replaces existing reasonable cost-based payments subject to Tax Equity and Fiscal Responsibility Act (TEFRA) limits under [section 1886 \(b\)](#) of the Social Security Act (the Act) for discharges occurring on and after the first day of the IPF's first cost reporting period beginning on or after January 1, 2005.

The IPF PPS, codified at [42 CFR 412](#), Subpart N, provides payment for inpatient psychiatric treatment when provided to an inpatient in psychiatric hospitals and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs).

190.2 - Statutory Requirements

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113), mandated that the Secretary—(1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. Section 124 of the BBRA also required that the IPF PPS be implemented for cost reporting periods beginning on or after October 1, 2002.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub.L. 108-173), [section 405\(g\)](#) extended the IPF PPS to distinct part psychiatric units of CAHs, effective for cost reporting periods beginning on or after October 1, 2004.

190.3 - Affected Medicare Providers

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Psychiatric hospitals and distinct part psychiatric units of acute care hospitals and CAHs are included in the IPF PPS and are referred to in these instructions as “inpatient psychiatric facilities” or “IPFs.” The regulations at [42 CFR 412.402](#) define an IPF as a hospital that meets the requirements specified in [42 CFR 412.22](#), [42 CFR 412.23\(a\)](#), [42 CFR 482.60](#), [42 CFR 482.61](#), and [42 CFR 482.62](#), and units that meet the requirements specified in [42 CFR 412.22](#), [42 CFR 412.25](#), and [42 CFR 412.27](#).

IPFs are certified under Medicare as inpatient psychiatric hospitals, which means an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to mentally ill patients, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and staffing requirements in [42 CFR 412.27](#) which mirror the requirements for a psychiatric hospitals in [42 CFR 482.60](#), [42 CFR 482.61](#) and [42 CFR 482.62](#).

The provider number ranges (OSCAR number) for IPFs are from xx-4000 through xx-4499, xx-Sxxx, and xx-Mxxx. Note that this will change with the implementation of National Provider Identifiers (NPI).

The following hospitals are not paid under the IPF PPS:

- *Veterans Administration hospitals; See [42 CFR 412.22 \(c\)](#).*
- *Hospitals that are reimbursed under state cost control systems approved under [42 CFR Part 403](#); Psychiatric Hospitals (provider numbers xx-4000 - xx-4499) in the State of Maryland are paid under the IPF PPS. Psychiatric distinct part units located in an acute care hospital in Maryland identified by 'S' in the third position of the OSCAR number are waived from the IPF PPS, as is the acute hospital in which they are located. Currently there are no CAHs in Maryland.*
- *Hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Pub. L. 90-248 (42 U. S. C. 1395b-1) or §222(a) of Pub. L. 92-603 (42 U. S. C. 1395b-1); See [42 CFR 412.22 \(c\)](#). IPFs in acute care hospitals that participate in demonstration projects are paid in accordance with the demonstration project;*
- *Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries are paid in accordance with [42 CFR 412.22 \(c\)](#).*
- *Payment to foreign hospitals is made in accordance with the provisions set forth in [42 CFR 413.74](#).*

190.4 - Federal Per Diem Base Rate

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Payments to IPFs under the IPF PPS are based on a single Federal per diem base rate computed from both the inpatient operating and capital-related costs of IPFs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct graduate medical education, and nursing and allied health education).

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate (which is broken into a labor-related share and a non-labor-related share) and applicable patient and facility adjustments that are described in §§190.5 and 190.6.

*The standardized Federal per diem base rates and adjustment factors are updated July 1 every year, beginning July 1, 2006. For the updated standardized Federal per diem base rates for subsequent years refer to the **Federal Register** rules and accompanying Recurring Update Notifications. See http://www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp*

190.4.1 - Standardization Factor

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The CMS standardized the IPF PPS Federal per diem base rate in order to account for the overall positive effects of the IPF PPS payment adjustment factors. To standardize the IPF PPS payments, CMS compared the IPF PPS payment amounts calculated from the FY 2002 MedPAR file to the projected TEFRA payments from the FY 2002 cost report file updated to the midpoint of the IPF PPS implementation period (that is, October 2005). The standardization factor was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. CMS then applied this factor to the average per diem cost of an IPF stay.

190.4.2 - Budget Neutrality

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The BBRA required that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented. Therefore, in the November 2004 IPF PPS final rule, CMS calculated the budget neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the TEFRA methodology had the IPF PPS not been implemented. CMS calculated the final Federal per diem base rate to be budget neutral during the

implementation period under the IPF PPS using a July 1 update cycle. The implementation period for the IPF PPS is the 18-month period of January 1, 2005 through June 30, 2006.

190.4.2.1 - Budget Neutrality Components

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The following are the three components of the budget neutrality adjustment:

(1) *Outlier Adjustment:* Since the IPF PPS payment amount for each stay includes applicable outlier amounts, CMS reduced the standardized Federal per diem base rate to account for aggregate IPF PPS payments estimated to be made as outlier payments. The appropriate outlier amount was determined by comparing the adjusted prospective payment for the entire stay to the computed cost per case. If costs were above the prospective payment plus the adjusted fixed dollar loss threshold amount, an outlier payment was computed using the applicable risk-sharing percentages. The outlier adjustment was calculated to be 2 percent of total IPF PPS. As a result, the standardized Federal per diem base rate was reduced by 2 percent to account for projected outlier payments;

(2) *Stop-Loss Adjustment:* CMS provides a stop-loss payment to ensure that an IPF's total PPS payments are no less than a minimum percentage of their TEFRA payment, had the IPF PPS not been implemented. CMS reduced the standardized Federal per diem base rate by the percentage of aggregate IPF PPS payments estimated to be made for stop-loss payments. As a result, the standardized Federal per diem base rate was reduced by 0.39 percent to account for stop-loss payments.

(3) *Behavioral Offset:* The implementation of the IPF PPS may result in certain changes in IPF practices especially with respect to coding for comorbid medical conditions. As a result, Medicare may incur higher payments than assumed in the calculations. Accounting for these effects through an adjustment is commonly known as a behavioral offset. The behavioral offset for the IPF PPS was calculated to be 2.66 percent. As a result, CMS reduced the standardized Federal per diem base rate by 2.66 percent to account for behavioral changes.

190.4.3 - Annual Update

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS is on a July 1st – June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006, and will occur every July 1 thereafter.

In accordance with [42 CFR 412.428](#), the annual update includes revisions to the Federal per diem base rate, the hospital wage index, ICD-9-CM coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) rate, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

190.4.4 - Calculating the Federal Payment Rate

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

To calculate an IPF PPS payment, follow the steps below:

1 - Multiply the Federal per diem base rate by the labor share.

2 - Multiply the resulting amount by the appropriate wage index factor.

3 - Multiply the Federal per diem base rate by the non-labor share.

4 - Multiply the resulting amount from this by any applicable cost-of-living adjustment (COLA) (Alaska or Hawaii).

5 - Add the adjusted labor portion of the Rate to the adjusted non-labor portion of the Rate (Add the results of steps 2 and 4). This is the Federal rate.

You must multiply this sum (step 5) by the all applicable facility and patient level adjustment factors described in §§190.5 and 190.6, to calculate the final payment.

CMS furnishes and maintains a PRICER program for intermediaries, and provides a PC PRICER that may be downloaded from the CMS Web site. The Web site is www.cms.hhs.gov/pcPricer

190.5 - Patient-Level Adjustments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Patient-level adjustments include a DRG adjustment, comorbidity adjustment, an age adjustment, and a variable per diem adjustment.

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS provides adjustments for 15 designated DRGs. Payment is made under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive the DRG adjustment in addition to all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the following psychiatric DRGs, the IPF will receive the Federal per diem base rate and all other applicable adjustments.

IPFs must submit claims providing the ICD-9-CM code of the principal diagnosis. To classify the case to the appropriate DRG, the GROUPER software for the hospital IPPS is used and the IPF PRICER applies the appropriate adjustment factor to the Federal per diem base rate.

Changes to the ICD-9-CM coding system are addressed annually in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information. Further information concerning the Official Version of the ICD-9-CM can be found in the IPPS final regulation.

The most current DRGs are posted on the IPF PPS Web site at www.cms.hhs.gov/InpatientPsychFacilPPS

The DRG adjustments are as follows:

DRG Title	DRG Code	Adjustment Factors
<i>O.R. Procedure w Principal Diagnosis of Mental Illness</i>	<i>DRG 424</i>	<i>1.22</i>
<i>Acute Adjustment Reaction & Psychosocial Dysfunction</i>	<i>DRG 425</i>	<i>1.05</i>
<i>Depressive Neurosis</i>	<i>DRG 426</i>	<i>0.99</i>
<i>Neurosis, except Depressive</i>	<i>DRG 427</i>	<i>1.02</i>
<i>Disorders of Personality & Impulse Control</i>	<i>DRG 428</i>	<i>1.02</i>
<i>Organic Disturbances & Mental Retardation</i>	<i>DRG 429</i>	<i>1.03</i>
<i>Psychosis</i>	<i>DRG 430</i>	<i>1.00</i>
<i>Childhood Mental Disorders</i>	<i>DRG 431</i>	<i>0.99</i>
<i>Other Mental Disorders Diagnoses</i>	<i>DRG 432</i>	<i>0.92</i>
<i>Alcohol/Drug Abuse or Dependence, LAMA</i>	<i>DRG 433</i>	<i>0.97</i>
<i>Alcohol/Drug Abuse or Dependence w CC</i>	<i>DRG 521</i>	<i>1.02</i>
<i>Alcohol/Drug Abuse or Dependence w/ Rehabilitation Therapy w/o CC</i>	<i>DRG 522</i>	<i>0.98</i>
<i>Alcohol/Drug Abuse or Dependence w/o Rehabilitation Therapy w/o CC</i>	<i>DRG 523</i>	<i>0.88</i>
<i>Degenerative Nervous System Disorders</i>	<i>DRG 12</i>	<i>1.05</i>
<i>Non-traumatic Stupor & Coma</i>	<i>DRG 23</i>	<i>1.07</i>

190.5.2 - Application of Code First
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

According to the ICD-9-CM Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable ICD-9-CM coding convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches the secondary codes for a psychiatric code to assign the DRG in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the CMS Web site at <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/>.

The most current Code First list is posted on the IPF PPS Web site at www.cms.hhs.gov/InpatientPsychFacilPPS

Code First Example

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

Four digit code 294.1 “Dementia in Conditions Classified Elsewhere”, is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 “Persistent Mental Disorders Due to Conditions Classified Elsewhere” appears in the ICD-9-CM as follows:

294.1 Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

- 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)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's Chorea" as the principal 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 for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG, the PRICER would search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.

190.5.3 - Comorbidity Adjustments
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that 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 not 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 or affect both treatment and the length of stay. IPFs enter the full ICD-9-CM codes for up to eight additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has 17 comorbidity categories, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-9-CM codes that are associated with each category is on the IPF PPS Web site at www.cms.hhs.gov/inpatientpsychfacilpps.

The 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	Adjustment Factor
<i>Developmental Disabilities</i>	<i>1.04</i>
<i>Coagulation Factor Deficits</i>	<i>1.13</i>
<i>Tracheostomy</i>	<i>1.06</i>
<i>Renal Failure, Acute</i>	<i>1.11</i>
<i>Renal Failure, Chronic</i>	<i>1.11</i>
<i>Oncology Treatment</i>	<i>1.07</i>
<i>Uncontrolled Diabetes-Mellitus with or without complications</i>	<i>1.05</i>
<i>Severe Protein Calorie Malnutrition</i>	<i>1.13</i>
<i>Eating and Conduct Disorders</i>	<i>1.12</i>
<i>Infectious Disease</i>	<i>1.07</i>
<i>Drug and/or Alcohol Induced Mental Disorders</i>	<i>1.03</i>
<i>Cardiac Conditions</i>	<i>1.11</i>
<i>Gangrene</i>	<i>1.10</i>
<i>Chronic Obstructive Pulmonary Disease</i>	<i>1.12</i>
<i>Artificial Openings - Digestive and Urinary</i>	<i>1.08</i>
<i>Severe Musculoskeletal and Connective Tissue Diseases</i>	<i>1.09</i>
<i>Poisoning</i>	<i>1.11</i>

190.5.4 - Age Adjustments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS has an age adjustment with 9 age categories; under 45, over 80, and categories in 5 year groupings in between. IPFs receive this adjustment for each day of the stay. The age adjustment is determined based on the age at admission and does not change regardless of the length of stay.

Age	Adjustment Factor
<i>Under 45</i>	<i>1.00</i>
<i>45 and under 50</i>	<i>1.01</i>
<i>50 and under 55</i>	<i>1.02</i>
<i>55 and under 60</i>	<i>1.04</i>
<i>60 and under 65</i>	<i>1.07</i>

<i>65 and under 70</i>	<i>1.10</i>
<i>70 and under 75</i>	<i>1.13</i>
<i>75 and under 80</i>	<i>1.15</i>
<i>80 and over</i>	<i>1.17</i>

190.5.5 - Variable Per Diem Adjustments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The variable per diem adjustments account for the ancillary and certain administrative costs that occur disproportionately in the first days after admission to an IPF. The variable per diem adjustments decline each day of the patient's stay through day 21. After day 21, the adjustments remain the same each day for the remainder of the stay.

<i>Day-of-Stay</i>	<i>Variable Per Diem Payment Adjustment*</i>
<i>Day 1 - Facility Without a Qualifying Emergency Department</i>	<i>1.19</i>
<i>Day 1 - Facility With a Qualifying Emergency Department</i>	<i>1.31</i>
<i>Day 2</i>	<i>1.12</i>
<i>Day 3</i>	<i>1.08</i>
<i>Day 4</i>	<i>1.05</i>
<i>Day 5</i>	<i>1.04</i>
<i>Day 6</i>	<i>1.02</i>
<i>Day 7</i>	<i>1.01</i>
<i>Day 8</i>	<i>1.01</i>
<i>Day 9</i>	<i>1.00</i>
<i>Day 10</i>	<i>1.00</i>
<i>Day 11</i>	<i>0.99</i>
<i>Day 12</i>	<i>0.99</i>
<i>Day 13</i>	<i>0.99</i>
<i>Day 14</i>	<i>0.99</i>
<i>Day 15</i>	<i>0.98</i>
<i>Day 16</i>	<i>0.97</i>
<i>Day 17</i>	<i>0.97</i>
<i>Day 18</i>	<i>0.96</i>
<i>Day 19</i>	<i>0.95</i>
<i>Day 20</i>	<i>0.95</i>
<i>Day 21</i>	<i>0.95</i>
<i>Over 21</i>	<i>0.92</i>

**The adjustment for day 1 would be 1.31 or 1.19 depending on whether the IPF has a qualifying emergency department or is a psychiatric unit in an acute care hospital or CAH with a qualifying emergency department (see §190.6.4).*

190.6 - Facility-Level Adjustments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Facility-level adjustments include the hospital wage index, a rural location adjustment, a teaching status adjustment, an emergency department adjustment for qualifying EDs, and a cost-of-living adjustment for IPFs located in Alaska and Hawaii.

190.6.1 - Wage Index

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The wage index accounts for the geographic differences in labor costs. The IPF PPS uses the unadjusted, pre-floor, pre-reclassified hospital wage index in effect on July 1 of each year. The wage index is applied to the labor-related share of the Federal per diem base rate.

Core-Based Statistical Area (CBSA) designations are used for assigning a wage index value for discharges occurring on or after July 1, 2006. Updates to the IPF PPS wage index are made in a budget neutral manner. CMS calculates a budget-neutral wage index adjustment factor by comparing estimated payments under the previous wage index to estimated payments under the updated wage index. This factor is applied in the update to the Federal per diem base rate.

190.6.2 - Rural Location Adjustment

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There is a 17 percent adjustment if a facility is located in a rural area. The IPF PPS defines urban and rural areas at [42 CFR 412.402](#).

190.6.3 - Teaching Status Adjustment

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs that train interns and residents receive a facility-level adjustment to the Federal per diem base rate. The cost of direct graduate medical education (DGME) and nursing and allied health education are not paid through the IPF PPS.

PRICER calculates the adjustment by adding 1 to the ratio of interns and residents to the average daily census (ADC), and then raising that sum to the 0.5150 power.

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. (See §190.6.3.1 for more detailed instructions for the FTE Resident Cap).

For beneficiaries enrolled in a Medicare Advantage plan, IPFs may bill for DGME and nursing and allied health education costs. There is no authority to pay teaching status adjustment to IPFs for Medicare Advantage beneficiaries, as is done under the IPPS.

190.6.3.1 - Full-Time Equivalent (FTE) Resident Cap

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There is a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. There is no limit to the number of residents teaching institutions can hire or train. There is only a limit to the number of residents who may be counted in calculation of the IPF PPS teaching adjustment. The cap is the number of FTE residents that trained in the IPF during a base year.

An IPF's FTE resident cap is determined based on the IPF's most recently filed cost report, filed prior to November 15, 2004. IPFs that first began training residents after November 15, 2004, will initially receive an FTE cap of zero. The FTE caps for new IPFs (as well as existing IPFs) that start training residents in a new DGME program (as defined in [42 CFR 413.79\(1\)](#)) may be subsequently adjusted in accordance with the policies that are being applied in the IPF PPS (as described in [42 CFR 412.424\(d\)\(1\)\(iii\)\(B\)\(2\)](#)).

IPFs are not permitted to aggregate the FTE resident caps used to compute the IPF PPS teaching status adjustment through affiliation agreements. Residents with less than full-time status and residents rotating through the psychiatric hospital or unit for less than a full year are counted in proportion to the time they spend in their assignment with the IPF (for example, a resident on a full-time, 3-month rotation to the IPF would be counted as 0.25 FTEs for purposes of counting residents to calculate the ratio). No FTE resident time counted for purposes of the IPFS Indirect Medical Education (IME) adjustment is allowed to be counted for purposes of the teaching status adjustment under the IPF PPS.

The denominator used to calculate the teaching status adjustment under the IPF PPS is the IPF's ADC from the current cost reporting period. If IPFs have more FTE residents in a given year than in the base year (the base year being used to establish the cap) payments are based on the lower number (the cap amount) in that year. If an IPF were to have fewer FTE residents in a given year than in the base year (that is, fewer residents than its FTE resident cap) an adjustment in payments in that year is based on the lower number (the actual number of FTE residents the facility trains).

190.6.3.2 - Reconciliation of Teaching Adjustment on Cost Report (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The teaching status 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 based on information from the cost report are adjusted through lump sum payments/recoupments when the cost report is settled.

The teaching adjustment is calculated as follows:

- 1. Determine the product of the wage-adjusted Federal per diem base rate and the applicable teaching, rural, DRG, comorbidity, and age adjustments.*
- 2. Determine the product of the wage adjusted base rate and the applicable rural, DRG, comorbidity, and age adjustments.*
- 3. Determine the difference of these two products (Step 1 minus Step 2).*
- 4. Calculate and sum the variable per diem amounts for the product in Step 2 to calculate the Federal payment net of the teaching adjustment amount.*
- 5. Calculate and sum the variable per diem amounts for the difference in Step 3 to calculate the portion of the Federal payment attributable to the teaching adjustment.*
- 6. To obtain the total Federal payment necessary for outlier calculations, etc., add Steps 4 and 5 together. Step 5 alone is the teaching adjustment portion of the Federal payment, and can be separately identified and reconciled on the cost report.*

190.6.4 - Emergency Department (ED) Adjustment (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

An adjustment is provided for IPFs that maintain a qualifying ED. This is a facility-level adjustment that applies to all IPF admissions (with the one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive a 31 percent adjustment as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 19 percent adjustment as the variable per diem adjustment for day 1 of each patient stay.

A qualifying ED means an ED of psychiatric units located in a hospital or CAH with EDs that are staffed and equipped to furnish a comprehensive array (medical as well as psychiatric) of emergency services and meets the definition of “provider-based status” ([42 CFR 413.65](#)) and meets the definition of a “dedicated emergency department” ([42 CFR 489.24](#)).

- “Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility that complies with the provisions of this section.” [42 CFR 413.65](#)
- “Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
 - (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
 - (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
 - (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.” See [42 CFR 489.24](#).

As specified in [42 CFR 412.424\(d\)\(1\)\(v\)\(B\)](#), the ED adjustment is not made where a patient is discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital’s or CAH’s psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient’s stay in the IPF.

IPFs should notify their Medicare contractors 30 days before the beginning of their cost reporting period regarding if they have a qualifying ED. Medicare contractors have the discretion to determine how they wish to be notified and the documentation they require. Once the Medicare contractor is satisfied that the IPF has a qualifying ED, the Medicare contractor should enter the information in the provider-specific file within a reasonable timeframe so that the IPF can begin to receive the ED adjustment. Application of the ED adjustment is prospective.

Medicare contractors may also use the date the documentation was received from the IPF to implement the ED adjustment. The provider-specific file can be updated from the date of the attestation and claims processed from that date will receive the ED adjustment. CMS does not intend that IPFs would have to wait until the beginning of their next cost report period to receive the ED adjustment.

However, if an IPF no longer meets the definition of a qualified ED, the IPF must promptly notify their Medicare contractor. The Medicare contractor would immediately remove the flag from the provider-

specific file and the provider will not receive the ED adjustment. If the provider should once again meet the definition of a qualified ED, they should contact their Medicare contractor immediately in order to update their file.

190.6.4.1 - Source of Admission for IPF PPS Claims for Payment of ED Adjustment (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Source of admission code "D" is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital or CAH. Claims with source of admission code "D" do not receive the ED adjustment.

See Pub. 100-04, Medicare Claims Processing Manual chapter 25, §60.1, FL 20 for additional instructions for completing the CMS-1450 data set.

190.6.5 - Cost-of-Living Adjustment (COLA) for Alaska and Hawaii (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. An adjustment for IPFs located in Alaska and Hawaii is made by multiplying the non-labor related share of the Federal per diem base rate and ECT rate by the applicable COLA factor.

The table below lists the specific COLAs for Alaska and Hawaii IPFs. The COLA factors were obtained from the U.S. Office of Personnel Management (OPM). The COLA factors are published on the OPM Web site (<http://www.opm.gov/oca/cola/rates.asp>). Any change in the COLA factors will be made in a Rate Year update document.

The COLA factors for Alaska and Hawaii IPFs are as follows:

County Receiving COLA	COLA Factor
Alaska (All Counties)	1.25
Hawaii, Honolulu County	1.25
Hawaii, Hawaii County	1.165
Hawaii, Kauai County	1.2325
Hawaii, Maui County	1.2375
Hawaii, Kalawao County	1.2375

190.7 - Other Payment Policies (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.7.1 - Interrupted Stays (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay. Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment and determining if the case qualifies for an outlier payment. In other words, an interrupted stay is treated as one stay and one discharge for the purpose of payment. Thus, the IPF should hold the claim for 3 days to ensure there is not a readmission that soon. In this way, the readmission is included on the original claim.

For example, if a patient leaves the IPF on 1/1 and returns to the same IPF on 1/3, this is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 – 1/2. Should the patient return to the IPF on 1/4, two bills are allowed.

In the case where an IPF patient is discharged from IPF “A” and within 3 days is readmitted to IPF “B,” and IPF “B” does not know about the patient’s immediately preceding hospitalization in IPF “A,” then 2 bills are allowed.

Medicare contractors should monitor trends to ensure IPFs are not consistently admitting, discharging, and readmitting patients in order to receive the larger variable per diem payments associated with the first days of a patient’s stay.

190.7.2 - Outlier Policy

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Additional payments are made for those cases that have extraordinarily high costs. If the estimated cost of the case is greater than the adjusted fixed dollar loss threshold amount (the fixed dollar loss threshold amount multiplied by area wage index, rural location, teaching and COLA), an additional payment is added to the IPF PPS payment amount.

The fixed dollar loss threshold amount is computed so that projected outlier payments are equal to 2 percent of total IPF PPS payments to ensure that IPFs treating unusually costly cases do not incur substantial losses and promote access to IPFs for patients who require expensive care.

Once the threshold amount is met, CMS will share a declining percentage of the losses for a high cost case. The risk-sharing percentages would be 80 percent of the difference between the cost for the case minus payment and the adjusted threshold amount for days 1 through 9 of the stay and 60 percent of the difference after the 9th day. Medicare contractors will determine the total outlier amount and divide by the number of days, then pay 80 percent for days 1-9 and 60 percent for days beyond that.

Outlier payments are not paid on interim bills, but they are calculated on a final discharge bill, a benefits exhaust bill, or if the patient falls below a covered level of care.

190.7.2.1 - How to Calculate Outlier Payments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

1 - Calculate the Adjusted Fixed Dollar Loss Threshold Amount

- Multiply the threshold amount by the labor share and the area wage index;*
- Multiply the threshold amount by the non-labor share 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.*

2 - 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 amounts is the total outlier payment.*

190.7.2.2 - Determining the Cost-to-Charge Ratio

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IPF PPS outlier methodology requires the Medicare contractor to calculate the provider's overall Medicare cost-to-charge ratio using the facility's latest settled cost report or tentatively settled cost report (whichever is from the later period), and associated data. Cost-to-charge ratios are updated each time a subsequent cost report is settled or tentatively settled. Total Medicare charges consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges including capital. Total Medicare costs consist of the sum of inpatient routine costs (net of private room differential and swing bed cost) plus the sum of ancillary costs plus capital-related pass-through costs only. Based on current Medicare cost reports and worksheets, specific instructions are described below.

Hospitals

For IPFs that are psychiatric hospitals, Medicare charges are obtained from Worksheet D-4, column 2, lines 25 through 30, plus line 103 from the cost report. Total Medicare costs are obtained from worksheet D-1, Part II, line 49, minus (Worksheet D, Part III, column 8, lines 25 through 30, plus Worksheet D, Part IV, column 7, line 101).

Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

Distinct Part Units

For IPFs that are distinct part psychiatric units, total Medicare charges are obtained from the Provider Statistical and Reimbursement Report (PS&R) associated with the applicable cost report. If the PS&R data is not available, the following method is used:

All references to Worksheets and specific line numbers should correspond with the sub-provider identified as the IPF unit that has the letter "S" or "M" in the third position of the Medicare provider number.

- *Estimate Medicare routine charges 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 the 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)*
- *Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.*

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

In order to receive the payment, an IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with [42 CFR 412.404\(d\)\(3\)](#), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers.

190.7.4 - Stop Loss Provision (Transition Period Only) ***(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)***

The IPF PPS includes a stop-loss provision during the 3-year transition. The purpose is to ensure each facility receives an average payment per case under the IPF PPS that is no less than 70 percent of its average payment under the TEFRA. It is calculated at cost report settlement. New providers are not eligible for stop-loss payments. See §190.9.1.

Example of stop-loss calculation in year 3 of the transition:

- 1. Enter Total (100%) TEFRA payments for cases during cost reporting period*
- 2. Enter Total (100%) PPS payments for cases during cost reporting period*
- 3. Multiply Step 1 by 0.70.*
- 4. If Step 3 is greater than Step 2, subtract Step 2 from Step 3. Otherwise, enter 0.*
- 5. Add Steps 2 and 4 to calculate total PPS payments.*
- 6. Multiply Step 1 by 0.25 to calculate the TEFRA portion.*
- 7. Multiply Step 5 by 0.75 to calculate the PPS portion.*
- 8. Add Steps 6 and 7 to calculate the IPF's aggregate payments in the third year of the IPF PPS. Determine if this amount is at least 70 percent of what would have been paid under TEFRA, then pay the difference.*

190.8 - Transition (Phase-In Implementation) ***(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)***

190.8.1 - Implementation Date for Provider ***(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)***

The IPF PPS is phased-in over 3 years from the cost based reimbursement to the Federal prospective payment. All IPF providers must transition over the 3-year transition period. There is no election of 100 percent PPS in the first year.

During the transition period, payment is based on an increasing percentage of the IPF prospective payment and a decreasing percentage of each IPF's TEFRA-based reimbursement rate for each case as follows:

Transition Year	Cost Reporting Periods Beginning on or After	TEFRA Rate Percentage	IPF PPS Federal Rate Percentage
1	January 1, 2005	75	25
2	January 1, 2006	50	50
3	January 1, 2007	25	75
	January 1, 2008	0	100

The 3-year transition period is separate from the annual update cycle of the IPF PPS. The transition is effective according to cost reporting periods, but the updates to the rates take effect July 1 of each year. For more detailed information regarding the annual update cycle, refer to §190.4.3-Annual Update.

Although the IPF PPS is effective January 1, 2005, an individual IPF's PPS transition year start date is the first day of the first cost reporting period that begins on or after that date. An IPF may begin the IPF PPS as early as January 1, 2005, or as late as December 31, 2005, should a cost reporting period begin on that date.

The IPF PPS applies to claims for discharges occurring in the IPF's first cost reporting period beginning on or after January 1, 2005. Where the IPF has already billed interim claims for an inpatient that has benefit days remaining after the PPS implementation date, the provider must submit a cancel bill and re-bill under the IPF PPS so that payment for the entire stay is made under the IPF PPS.

If the provider ever had a TEFRA limit, the IPF is not a new provider and therefore will receive the blended payment. This includes those providers that previously closed their psychiatric units and then re-opened the psychiatric units. If the provider had a TEFRA limit established, that TEFRA limit is updated using the rate of increase percentages in [42 CFR 413.40](#).

For cost reporting periods beginning in FY 1999 through FY 2002, the applicable rate-of-increase percentage is the market basket increase percentage minus a factor based on the percentage by which the hospital's operating costs exceed the hospital's ceiling for the most recently available cost reporting period.

To update the TEFRA limit for IPFs that were closed during FY 1999 through FY 2002 and then re-opened (including CAHs that were statutorily precluded from having a distinct part unit), the rate-of-increase for these years would be the full market basket up to the cap on the target amounts.

190.9 - Definition of New IPF Providers Versus TEFRA Providers (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.9.1 - New Providers Defined (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A new IPF provider is one that meets the definition of an IPF in [42 CFR 412.402](#), and under present or previous ownership or both, has not received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005. To be a new provider, the first cost reporting period as a psychiatric hospital, a distinct part unit in an acute care hospital or a CAH must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.

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

190.10 - Claims Processing Requirements Under IPF PPS (Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

190.10.1 - General Rules

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE:** Implementation of NPI will change this.)
- The IPF must code diagnoses correctly; using ICD-9-CM codes for the principal diagnosis, and up to eight additional diagnoses, if applicable;
- The IPF must code procedures correctly using ICD-9-CM Volume III codes for one principal procedure and up to five additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and
- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date on the claim will determine the DRG assignment.

190.10.2 - Billing Period

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPF providers will submit one admit through discharge claim for the stay upon discharge. IPFs may interim bill in 60-day intervals following the instructions in chapter 1, §50.2 of this manual should the patient's stay be exceptionally long. Final PPS payment is based upon the discharge bill.

IPFs can submit adjustment claims, but late charge claims will not be allowed, e.g., the adjustment claim must include all charges and services and must replace the earlier claim(s) instead of including only the additional charges and services.

In situations when a patient falls below a skilled level of care, IPFs should submit a 112 TOB with both an Occurrence Code 22 (Date active care ended) and patient status code 30 (Still a patient). IPFs should then continue to submit subsequent interim 117 TOBs, as appropriate, with the patient status code 30 and the correct Occurrence Span Codes that identify payment liability (codes 76 or 77).

190.10.3 - Patient Status Coding

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

All patient status (i.e., discharge disposition) codes for 11X TOB are valid, but there are no special payment policies related to transfer codes; for example, discounted or per diem payments in transfer situations. The same patient status codes applicable under inpatient PPS for same day transfers (with Condition Code 40) are applicable under IPF PPS.

190.10.4 - Reporting ECT Treatments

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs must report on their claims under Revenue Code 0901, along with the total number of ECT treatments provided to the patient during their IPF stay listed under "Service Units." Providers will code ICD-9-CM procedure code 94.27 in the procedure code field and for the procedure date will use the date of the last ECT treatment the patient received during their IPF stay.

190.10.5 - Outpatient Services Treated as Inpatient Services

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs are subject to the 1-day payment window for outpatient bundling rules. Refer to chapter 3, §40.3 of this manual for more information on bundling rules.

190.10.6 - Patient is a Member of a Medicare Advantage Organization for Only a Portion of a Billing Period

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The payer at the time of the patient's admission to an IPF is responsible for the cost of the entire stay. This could occur for patients who move from traditional Medicare to a Medicare Advantage plan or vice versa.

190.10.7 - Billing for Interrupted Stays

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

IPFs shall bill for the interrupted stay using Occurrence Span Code 74. The Occurrence Span Code FROM date equals the day of discharge for the IPF and the THROUGH date is the last day the patient was not present in the IPF at midnight. For example, the patient leaves the IPF on 1/1 and returns to the IPF on 1/3. This is considered an interrupted stay and the Occurrence Span Code 74 will show 1/1 - 1/2. Should the patient return to the IPF on 1/4, two bills will be allowed. The accommodation Revenue Code 018X (RT 50, field 5), (SV 201), (leave of absence) will continue to be used in the current manner in terms of Occurrence Span Code 74 (RT 40, field 22 – 27) and date range.

190.10.8 - Grace Days

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no grace days allowed under IPF PPS, therefore the date the beneficiary is notified of the provider's intent to bill (Occurrence Code 31) is the last covered day for that patient.

190.10.9 - Billing Stays Prior to and Discharge After PPS Implementation Date

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under IPF PPS, payment to the facility is based on IPF PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment (see chapter 1, §50.2 of this manual). If the facility submitted multiple interim bills, the facility will need to submit cancels for all bills and then re-bill once the cancels are accepted.

Exceptions:

If the beneficiary's benefits were exhausted or the beneficiary is in a non-covered level of care prior to implementation of IPF PPS, then IPF PPS is not applicable and the IPF will continue to submit no-pay bills (TOB 110) to Medicare.

190.10.10 - Billing Ancillary Services Under IPF PPS
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

There are no special rules for billing IPF inpatient ancillary services.

190.10.11 - Covered Costs Not Included in IPF PPS Amount
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The following covered services are not included in the IPF PPS discharge payment amount:

- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS.*
- DGME and bad debts.*

190.10.12 - Same Day Transfer Claims
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

A same day transfer occurs when a patient is admitted to an IPF and is subsequently transferred for acute care (or another type of inpatient facility care) on the same day. If the patient is admitted to an IPF with the expectation that the patient will remain overnight, but is discharged before midnight, the day is counted as a full day for the cost report, but is not counted as a Medicare covered day for purposes of charging the beneficiary utilization.

IPFs should show the same day for admission and discharge, and report Condition Code 40 (Same Day Transfer).

If the patient is admitted to an IPF and discharged (not transferred to another inpatient setting) the same day before midnight, the day is counted as a full day for the cost report, and is counted as a Medicare covered day for purposes of charging the beneficiary utilization. IPFs do not report Condition Code 40 on this case.

The purpose for the variance in coding is to charge the beneficiary only 1 day utilization where two facilities are billing. Payment will be made for 1 day.

190.10.13 - Remittance Advice - Reserved
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Not yet available.

190.10.14 - Medicare Summary Notices and Explanation of Medicare Benefits
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Existing notices for inpatient hospital PPS are used.

190.11 - Benefit Application and Limits-190 Days
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per [42 CFR 409.62](#). The 190-lifetime limitation does not apply to psychiatric certified distinct part units. Section 409.62 states, “There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual.”

The Benefit Period provisions described in Medicare Publication 100-01, Medicare General Information, Eligibility, and Entitlement, chapter 3, [§§10.4-10.4.4](#) are applicable to inpatients in either a freestanding psychiatric hospital or a distinct part.

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. This limitation applies only to services furnished in a psychiatric hospital. This limitation does not apply to inpatient psychiatric services furnished in a hospital, a CAH or distinct part psychiatric unit. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

The CWF keeps track of days paid for inpatient psychiatric services and informs the Medicare contractor on claims where the 190-day limit is reached.

For a more detailed description see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §30.C. and chapter 4, §50 for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services. For details concerning the pre-entitlement inpatient psychiatric benefit reduction provision see Pub. 100-02, Medicare Benefit Policy Manual, chapter 4, §§10 - 50.

190.12 - Beneficiary Liability

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system. An IPF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

An IPF receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least 1 covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under [42 CFR 409.82](#), [42 CFR 409.83](#), and [42 CFR 409.87](#) and for items or services as specified under [42 CFR 489.30](#).

For more detailed information regarding lifetime reserve days, refer to Pub. 100-02 Medicare Benefit Policy Manual, chapter 5.

190.13 - Periodic Interim Payments (PIP)

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Medicare contractors shall pay PIP for providers who send a request to their Medicare contractor and qualify. Outlier payments, teaching adjustment, and ECT add-on payments are not included in the PIP payment amount but are paid on the discharge claim for ECT, and on a discharge, benefits exhaust, or last day of a Medicare covered level of care claim, for the teaching adjustment and outlier payment.

190.14 - Intermediary Benefit Payment Report (IBPR)

(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The IBPR report has been changed to reflect the payments for IPFs going to PPS psychiatric hospitals and units.

190.15 - Monitoring Implementation of IPF PPS Through Pulse
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

The FISS 620A and 620B reports will be modified to add an additional row for IPF monitoring. The report will be modified to include a separate reporting line titled "IPF PPS." This entry will appear immediately below "IPF PPS" and report the total claim count and total reimbursement amount. IPF PPS totals will include all providers with the last four digits of the provider numbers in range 4000 – 4499, xx-Sxxx, and xx-Mxxx.

190.16 - IPF PPS System Edits
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines, and
- the length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

CWF shall ensure that Occurrence Span Code 74 FL36, (RT 40, fields 22, 24, 26), (2300 loop HI code BI), is present on the claim when there is an interrupted stay (the beneficiary has returned to the IPF within 3 days).

190.17 - IPF PPS PRICER Software
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

CMS has developed an IPF PRICER program that calculates the Medicare payment rate. PRICER software will be electronically supplied to the Standard Systems. A Personal Computer (PC) version of this PRICER will be available on the CMS Web site in the future at <http://www.cms.hhs.gov/PCPricer>.

PRICER will incorporate the 3-year phase-in period for all current IPFs. New IPFs will be paid completely under the new IPF PPS (i.e., there is no transition for new IPFs).

190.17.1 - Inputs/Outputs to PRICER
(Rev.1101, Issued: 11-03-06, Effective: 01-01-05, Implementation: 12-04-06)

Provider Specific File Data

Data Element	Title
1	National Provider Identifier (not a mandatory entry at this time)
2	Provider Oscar Number
3	Effective Date
4	Fiscal Year Begin Date
5	Report Date
6	Termination Date
7	Waiver Indicator

9	<i>Provider Type (must be 03 or 06) Effective July 1, 2006, 06 is no longer valid. Contractors shall use 49.</i>
12	<i>Actual Geographic Reclassification-MSA (no longer applicable effective July 1, 2006)</i>
17	<i>Temporary Relief Indicator (For IPF PPS, code Y if there is an Emergency Department)</i>
18	<i>Federal PPS Blend Indicator (must be 1, 2, 3, or 4)</i>
21	<i>Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate (This is determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the IPF PPS were not being implemented.)</i>
22	<i>Cost of Living Adjustment (COLA)</i>
23	<i>Intern/Bed Ratio</i>
25	<i>Combined Capital and Operating Cost to Charge Ratio</i>
33	<i>Special Wage Indicator (should be set to 1 if there is a change to the wage index.)</i>
35	<i>Actual Geographic Location Core-Based Statistical Area (CBSA) (required July 1, 2006)</i>
38	<i>Special Wage Index</i>
48	<i>New Hospital</i>

Bill Data

<i>National Provider Identifier</i>	<i>Covered Charges</i>
<i>OSCAR Number</i>	<i>Discharge Date</i>
<i>Patient Age</i>	<i>Other Diagnosis Codes</i>
<i>DRG</i>	<i>Other Procedure Codes</i>
<i>Length of Stay</i>	<i>Indicator for Occurrence Code 31, A3, B3, or C3 to apply outlier to this bill.</i>
<i>Source of Admission</i>	<i>ECT Units</i>
<i>Patient Status Code</i>	<i>Claim Number</i>

Outputs

In addition to returning the above bill data inputs, Pricer will return the following:

Final Payment

*DRG Adjusted Payment
Federal Adjusted Payment
Outlier Adjusted Payment
Comorbidity Adjusted Payment
Per Diem Adjusted Payment
Facility Adjusted Payment
Age Adjusted Payment
Rural Adjusted Payment
Teaching Adjusted Payment
ED Adjusted Payment
ECT Adjusted Payment
Return Code*

National Non-Labor Rate

*Federal Rate
Budget Neutrality Rate
Outlier Threshold
Federal Per Diem Base Rate
Standardized Factor
Labor Share
Non-Labor Share
COLA
Day of Stay Adjustment
Age Adjustment
Comorbidity Adjustment
DRG Adjustment*

*MSA/CBSA
Wage Index
National Labor Rate*

*Rural Adjustment
ECT Adjustment
Blend Year Calculation Version*